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Initiatives to Engage Private-Practice Physicians in the Mission of Academic Medical Centers

Douglas C. Appleby
Medical University of South Carolina

INITIATIVES TO ENGAGE PRIVATE-PRACTICE PHYSICIANS IN THE MISSION OF ACADEMIC MEDICAL CENTERS

BY

DOUGLAS C. APPLEBY, JR., M.D.

A doctoral project submitted to the faculty of the Medical University South Carolina in partial fulfillment of the requirements for the degre Doctor of Health Administration
In the College of Health Professions

DEDICATION

Dedicated with enduring love to my parents,

Buena F. Appleby and Douglas C. Appleby, M.D.,

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DOUGLAS C. APPLEBY, JR., M.D.

Approved by:

Chair, Project Committee	Michael T. Ryan, Ph.D., C.H.P.	17 MAR 04 Date
Member, Project Committee	Donald L. Fowler, Ph.D.	17 Mar 04 Date
Member, Project Committee	Thomas E. McIlwain, Ph.D.	3-17-04 Date
Member, Project Committee	Elizabeth A. Wennar, M.P.H., D.H.A	03/08/04 Date

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ENGAGING PRIVATE-PRACTICE PHYSICIANS IN THE MISSION OF ACADEMIC MEDICAL CENTERS THROUGH A COLLABORATIVE MODEL

By

Douglas C. Appleby, Jr., M.D.

Chairperson: Michael T. Ryan, Ph.D., C.H.P.
Committee: Donald L. Fowler, Ph.D.
Thomas E. McIlwain, Ph.D.
Elizabeth A. Weiner, M.P.H., D.H.A.

Abstract

Today's healthcare market presents many challenges to academic healthcare centers and community-based physicians given the constrained resources and competition for healthcare dollars. Never before has the business sector infiltrated the healthcare market to this extent. Monies previously directed toward graduate medical education from government resources and cost-shifting practices have been abolished, and these changes have jeopardized the founding missions governing academic medical centers. However, community-based private practitioners—both educated and clinically trained at these centers of higher learning, provide an enormous pool of expertise to help rectify many current problems. Collaboration between these private practitioners and the medical centers could create positive change, to the mutual benefit of both groups. This research examines the problems facing medical schools in meeting their three-fold mission of education, clinical care, and research; and it presents a model for collaboration that could aid both the stakeholders and the healthcare system as a whole.

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CHAPTER ONE

Introduction

Medical schools are charged—through individual and collective social contracts—to provide healthcare to their constituents, train physicians and other health care professionals, and conduct research to advance medical science. The foremost obligation of these schools and their affiliate teaching hospitals is to improve the nation's health by passing along their knowledge to a new generation of physicians and healthcare professionals (McCurdy et al., 1997). Medical schools have accomplished much by fulfilling their missions to provide excellence in patient care, teaching, and research in an environment that adapts to change and accounts for outcomes. This core mission underlies the conceptual framework of all academic medical centers (AMCs).

Medical schools have operated from this framework for generations and continue to do so. Currently changes in the politics, economics, and government funding for healthcare have brought about the need for additional changes. While the academic medical center's mission has expanded in recent decades, simultaneously financing academic medicine and its relationship to the central mission has become unbalanced (Rabkin, 1998). In the first decade of the 21st century, healthcare resources continue to shrink, and AMCs are having an increasingly difficult time meeting their traditional

mission: education, research, and clinical care. At this critical juncture, medical school leaders and healthcare professionals must recognize the importance of examining their perspectives and assumptions about both their institutions and their constituents to successfully improve strategic planning, policy-making, and program development.

The last 50 years have seen major efforts to shore up and improve public health at both the state and federal levels, most notably in the academic arena. Federal support, in the form of millions of taxpayers' dollars, flows through programs such as the National Institutes of Health, the National Science Foundation, the huge Medicare/Medicaid network, and various public health research initiatives (McCurdy, 1997). More than any other institutions, medical schools and teaching hospitals hold out to the public the promise of modern healthcare. These institutions measure the overall soundness of our healthcare system (Levey & Anderson, 1999).

These avenues of reform, however, have been disconcertingly narrowed and blocked in more than a decade of so-called healthcare "reforms" in which cutbacks in public funds have resulted in the largest reduction in expenditures for teaching hospitals and medical schools in the entire history of academic medicine (Iglehart, 1999b). These institutions have been put at risk in the government's attempts to achieve a balanced federal budget, and this risk has caused a large segment of the public to view the nation's entire healthcare system as failing. The draining effects of funding cuts and possible solutions to this problem seem especially startling in the context of the development of medical schools and their missions of providing the lead in healthcare.

This paper will examine the relationship between the private-sector physician and AMCs. Currently, they are not engaged in collaborative ways. Private physicians often

seem unaware that collaboration would benefit them in their practice and benefit the AMCs as well. PPPs must help lead initiatives in healthcare. Although physicians tend to focus on the profitability and financial success of their practices, a variety of strategies could be developed and implemented to engage the private physician in the arena of the AMC. Given the financial constraints placed on funding graduate medical education, solutions must be found to combat the increasingly complex bureaucracy and its effect on future healthcare.

The Mission in Historical Perspective

In the late 19th century, little was required for one to become a physician. Medical schools were owned by the instructors, for whom profit was a major goal. Paying the fees was the only entrance requirement. The program usually required the student to attend two 16-week terms of lecture, with much of the material being repeated during the second term. The instruction was primarily didactic, a teaching technique focused on direct instruction by lecture and reading texts, not clinical experience or laboratory work Teaching was an end in and of itself, and patient care was pursued only insofar as it facilitated teaching. American students who wanted to know more in general or to specialize had to go to Europe for scientific medical instruction (Ludmerer, 1999).

A revolution in American medical studies began in 1910 when Abraham Flexner penned his famous report, *Medical Education in the United States and Canada*, attacking medical schools for being too commercial and for adhering to low standards (Ludmerer, 1999). Flexner's exposé moved him to the forefront of educational reform, and he earned a position as secretary of the General Education Board. After a period of skeptical

opposition, some medical universities adopted his strategic plan for graduate medical education (Ludmerer, 1999).

Flexner called for medical schools to become university-based. Under his plan medical training now required four years of nine-month terms. Didactic teaching played a much smaller role, largely replaced by laboratory and clinical training. Even before Flexner's report called the public's attention to these deficiencies, improved medical training had begun at Harvard, Johns Hopkins, and other eastern medical schools. The universities provided the infrastructure including laboratories, teaching facilities, and full-time instructors. New medical schools were strongly committed to medical research and expansion of new clinical training opportunities through hospital affiliations. Later, in the first third of the 20th century, the quality of American medical training began to exceed that of European medical schools (Ludmerer, 1999).

The medical schools' three-fold mission of patient care, education, and research had been present from the beginning, but the relative importance of these activities was shifting. Whereas medical practice had once clearly lagged behind medical knowledge, the gap was now closing. Improvements in medical education now translated into an improvement in the level of practice and patient care. The Flexnerian revolution meant that patients could now feel confident about the level of care they were receiving (Ludmerer, 1999).

By the mid-20th century, as medical schools affiliated with universities, the focus of medicine became education, not profit, especially during the time between World War I and World War II, considered the educational era. Medical schools faced the challenges of responding to the rapidly changing environment without compromising their core

value of service to society or their core mission of education, research, and patient care. After World War II, however, research began to replace teaching as the dominant activity in AMCs, largely because the National Institute of Health expanded. From World War II until about 1965, clinical medicine grew quickly into a major component of medical schools. The new system of medical education met the needs of the public as well as those of the academic physicians. An implicit social contract emerged: medical schools would provide skilled physicians to meet society's needs, and society would pay for the required facilities and teachers so that training would be held to high standards. Even private physicians became involved, by becoming "voluntary" clinical faculty members. Eventually the line between academic medicine and private practice blurred. Private physicians not only taught, but also contributed to clinical research (Ludmerer, 1999; Korn, 1998; Johnson & Jones, 1993).

As medical education became grounded in scientific experimentation, hospitals became requisite for clinical research and medical education (Levey, 1999). Although care for the indigent had been the foundation of major teaching hospitals, after World War II, hospital administrators led teaching hospitals to de-emphasize their image as care-takers of the indigent and to emphasize their growing, highly specialized services. This shift in image coincided with a shift in the balance of power, moving it away from academic physicians and toward hospital administrators (Levey, 1999).

The Development of Funding for Medical Schools

Before 1910, the budget for a major medical school averaged $100,000, and obtaining this funding was difficult. After the Flexner report, medical schools received large amounts of money – literally hundreds of millions of dollars – primarily from such

large national foundations as the General Education Board and the Carnegie Corporation (Ludmerer, 1999). Funding also became available through other sources: state and local governments, tuition revenues, and gifts from citizens, endowments, and private philanthropists. The development of medical science and experimental research over the next 50 years created new excitement, and as a result more and more funding became available. Federal aid came mainly in the form of research grants from the National Institutes of Health. Faculty physicians generated only a minimal amount of income for medical schools (Kuttner, 1999).

Medicare was enacted in 1965, primarily to provide health insurance to some 38.4 million elderly or disabled Americans, as well as to those suffering from chronic and resource diseases such as end-stage renal disease (Iglehart, 1999b; see Ludmerer, 1999). The bill also covered rural healthcare facilities, which lacked the means to operate without public subsidies. Supplementary provisions in the law allowed the federal government to begin supporting academic centers in four ways – paying customary charges, making grants for graduate medical education, supplementing payments to hospitals with a disproportionate share of costly cases, and helping offset the institution's overhead (Kuttner, 1999).

In 1983, Medicare instituted a prospective-payment system that paid hospitals (including teaching hospitals) based on the diagnosis, not the treatment. Private insurance companies soon began doing the same (Kuttner, 1999). The primary source of funding academic health centers (AHCs) was patient care, accounting for about 90% of revenues, with roughly 50% of the total net patient care revenues coming from Medicare/Medicaid (Freburger & Hurley, 1999). Medical schools receive funding from

faculty practice plans (34.2%), grants and contracts (29%), hospital/medical school programs (5.7%), state and local coffers (8.5%), and tuition and fees (3.9%) (Freburger & Hurley, 1999).

In 1997, President Bill Clinton signed into law the Balanced Budget Act , with its goal of balancing the federal budget by 2002 (Davis, 2000). This bill represented Medicare's largest cuts in spending for hospitals in its history (Iglehart, 1999b). In introducing the Medicare bill to the House of Representatives in 1965, the language of the Ways and Means Committee was unambiguous: " . . . educational activities enhance the quality of care of an institution, and it is intended, until the community undertakes to bear such education costs in some other way that Medicare should pay part of these costs" (AAMC, 1999c). Medicare is by far the largest contributor among both public and private agencies whose missions include support of public health initiatives (Iglehart, 1999b; Levey & Anderson, 1999).

Not surprisingly, the motivation behind the Balanced Budget Act (BBA) was, at least in part, political. What better means existed to eliminate the federal budget deficit, to reduce federal spending, and to allow tax cuts over the period 1998-2002? That $119 billion of the anticipated total cut of $250 billion that would result from reduced the growth in Medicare spending was irresistible to lawmakers (Iglehart, 1999b).

An estimated two-thirds of the Medicare savings anticipated during that five-year period would come from lowering payments to all physicians and hospitals (Iglehart, 1999b). This burden, which many believe fell disproportionately on providers, can be explained by several political realities. Medicare was both vulnerable and an easy target for budget cuts precisely because of its status as a fast-growing federal entitlement

program. Also legislators knew that 20 years of cutting increases in payments to physicians and hospitals had not caused any sort of revolt among healthcare providers, at least none threatening enough to influence elections. Moreover, the constituency that influences legislators most – Medicare beneficiaries – did not see these reductions as a threat to their own expectations of high-quality healthcare, and so they actually had a vested interest in not resisting the cutbacks (Iglehart, 1999b).

AMCs were especially hit particularly hard by the 1997 budget act because the BBA not only cut all hospitals' payments for patient care and capital, but also reduced payments to hospitals that treat a disproportionately large number of indigent patients. It also cut funds for teaching activities, support upon which schools had come to depend. Previously Medicare had paid for residency training, including some of the salaries and benefits paid to residents and their supervising physicians. These direct subsidies and related expenses, which totaled $2.2 billion in 1998, were scheduled to be cut by about $700 million by 2002 (Iglehart, 1999b).

The impact continues. Cuts have also weakened such indirect costs of medical education as patient care at teaching hospitals; specialty care for severe disorders; support of trauma centers and burn units; and unsponsored clinical research. Although Medicare funds of $4.1 billion in fiscal year 1998 were almost twice the funds paid in 1990 on similar items labeled "indirect costs," the bill was to reduce these payments by some $5.1 billion by 2002 (Iglehart, 1999b).

AMCs across the country treat millions of patients, train thousands of residents, and employ a highly skilled work force. In short, their activities constitute a major contribution to society. Unless there develops "a broad-based campaign—one that

engages the patients served by these institutions, the influential people on their boards of directors, and the highly trained staffs that they employ, academic medical centers run the risk of having their future determined by external forces . . ." (Iglehart, 1999b, p. 304). These external forces unfortunately have the capacity to wreak permanent havoc on the crucial endeavors of education, patient care, and research, for which these institutions carry the front-line responsibility (Iglehart, 1999b).

The American system of healthcare, particularly as it relates to medical education, is at risk without innovative approaches to reestablish stable sources of funding for patient care, medical education, and research. One of the overlooked or untapped resources is the private-practice physician (PPP). Currently, the gap between the private sector and AHCs is striking: a physician can complete his or her medical training at an AMC and then build a practice that directly competes with the institution that trained him or her. The private physician enters this competition having little regard for and less involvement with the very school from which he or she emerged. Physicians are therefore divorced from their parent institutions. Unless individual efforts are made to bridge this gap, nothing tends to happen, as there is no formal, structured program or model for collaborative involvement between community practitioners and those within academe.

Purpose and Scope of the Study

In investigating the possible roles PPPs could play in collaborating with AMCs, this paper will examine the current problems facing our medical schools in meeting their tripartite mission of clinical care, education, and research. The factors that contributed to this problem and the strategies that can be implemented to create a win-win scenario for

all parties will be developed from surveys of private- practice physicians and leaders in academic medicine as well as heeding possibilities discussed in the current literature. The key premise to be examined is whether collaborative efforts among private physicians interacting with medical school leaders, government officials, and the public can create positive change to fulfill the missions of AMCs in an era of funding cuts that tend to thwart the very core efforts of these centers for advanced medical education. The impact of these financial constraints is far reaching to both the AMC and PPP alike. The research will identify ways in which AMCs can meet their threefold mission by leveraging the skills and strengths of the PPP. This research will propose models to help close the gap between PPPs and university healthcare systems that take advantage of the strengths of both groups to improve the delivery of healthcare, education, and research at the AMC.

Definition of Terms

AHC – Academic Health Centers: Academic medical centers with enlarging responsibilities, including expanding community service, home care, hospice care, and nursing home care.

AMC – Academic Medical Centers; ATH – Academic Teaching Hospitals: Interchangeably used terms. Centers typically consisting of a medical school, a university-owned or controlled hospital, and affiliated specialty hospitals or institutions; a hospital primarily affiliated with an Academic Medical Center geared toward graduate medical education.

BBA—Balanced Budget Act of 1997.

Cross-subsidization: Patient care revenues generated by faculty practice plans and affiliated hospitals of the AHC used to supplement educational and research activities and to cover the costs of uncompensated care.

COGME – Council on Graduate Medical Education: Authorized by Congress in 1986; 17 appointed members who provide an ongoing assessment of physician workforce trends, training issues, and financial policies, and recommend appropriate federal and private sector efforts to address identified needs.

DME – Direct Medical Education: Type of Medicare payment that helps defray the direct costs of training physicians, such as the salaries and fringe benefits of medical residents and faculty, and hospital overhead expenses.

DRG – Diagnosis Related Groups: Prospective payment of hospital bills for Medicare patients; a set fee per case, determined by the patient's diagnosis; established in 1983.

FPP – Faculty Practice Plan: Organized group practices consisting of full-time and voluntary clinical faculty of the medical school. In a typical plan, full-time faculty sign an authorization card that allows the administrator of the plan to bill in their names for services rendered to private patients.

GME – Graduate Medical Education: The formal graduate education that students receive after medical school – internship and residency.

IME – Indirect Medical Education: Type of Medicare payment that covers the additional operating costs teaching hospitals incur in patient care, such

as the costs associated with offering a broader range of services, using more intensive treatments, using more diagnostic services, requiring the latest technologies, facing sicker patients, and using a costlier staff mix.

PPP—Private-Practice Physician: Independent medical clinicianunaffiliated with an AMC.

CHAPTER TWO

Review of Literature

Recent literature addresses many potential threats to healthcare, including problems in funding graduate medical education and healthcare delivery through the AMC. Some of these problems have resulted from decreasing reimbursement, primarily the effects of the BBA. The literature has also discussed the competitive medical environment engendered by the competitive gap between PPPs and the AHCs' physicians who are seeking patients. In such an environment, the instructional and educational mission of AMCs is severely jeopardized.

Key Questions

Current literature has raised many questions about the complexities of interrelated demands on AHCs. What is the relationship between alumni and their alma mater? How has the emerging competition between private practice and the AMC healthcare delivery system affected the relationship both in terms of cooperation and competition? (MacLeod et al., 1987). What additional internal and external forces threaten medical institutions? How have private "alumni" physicians remained disconnected, apathetic, or unaware in the face of these threats? (MacLeod et al., 1987). What solutions can be found in the wealth of a medical sector that – thanks to mentors in AHCs – has provided physicians with proficiency, knowledge, and a base from which to deliver state-of-the-art clinical

care? In short, how can PPPs become participants in and progenitors of engagement with the AMC? These questions will be examined in this chapter.

Recent Assessments of Threats to Medical Institutions

Although little empirical analysis has appeared, current literature nevertheless offers insights into the forces currently threatening medical institutions, and understanding these insights is essential in developing a model for collaboration between PPPs and AMCs. Most of this information is anecdotal, speculative, or descriptive (Freburger & Hurley, 1999; Kuttner, 1999).

Effects of the Balanced Budget Act

One of the major issues affecting the funding of AHCs is the reduction in Medicare/Medicaid spending mandated in the BBA. This budget proposal is considered to be a hodgepodge of healthcare initiatives that proposed large decreases in funds as well as tax cuts in the government's attempt to balance the federal budget by 2002 (Freburger & Hurley, 1999). These reductions have, in fact, been severe to both hospitals and providers (Watkins, 2000; Muller, 2001). Iglehart (1999a) suggests that "the changes included in the Balanced Budget Act are strictly a down payment in terms of closing Medicare's funding gap" (p. 331). While the BBA was intended to balance the federal budget, it may have yielded other unintended consequences by financially hurting some of the nation's teaching hospitals (Dickler & Shaw, 2000). When the BBA was enacted, budget analysts estimated that two-thirds of the projected Medicare savings during the five-year period would be derived from reductions in payments to all physicians and hospitals, placing a disproportionate load on providers (Iglehart, 1999b). According to Iglehart (1999b), AMCs were particularly affected by the 1997 budget as a result of

reduced payments to hospitals, as well as reduced subsidies for teaching. In addition, direct payments for residency training, as well as indirect payments for medical education, were scheduled for phased reductions, representing a serious blow to AHCs. As a result of these cuts, teaching hospitals are no longer able to bill at rates that reflect the extra costs of their academic role, therefore forcing these AMCs to ration their resources carefully and make difficult choices in meeting mission goals (Kuttner, 1999). Davis (2000) states that the BBA capped the number of residents qualifying for reimbursement and initiated a phased-in decrease in the IME adjustment factor, two of the changes that cause the most concern. The BBA is considered one of the major factors threatening the complex fabric of direct revenue, transfer payments, and cross-subsidies (funds generated by faculty practice, used to cover uncompensated costs) on which academic medicine relies (Weiner, Culbertson, Jones & Dickler, 2001).

Some authors state that teaching hospitals suffered disproportionate negative effects under the BBA (AAMC, 1999a; see also Iglehart, 1999b; Fox, 1999). Not only did the law decrease payments, but it also cut Indirect Medical Education by 28.6 percent from 1998 to 2001. Dickler, a Senior Vice President on the staff of the Association of American Medical Colleges, and Shaw (2000) also think that the budget law had a disproportionate impact on U.S. teaching hospitals. These effects may possibly undermine the teaching hospitals' provisions for both functioning and funding programs in education, research, and service. Some of the BBA's specifications focus on teaching hospitals. One, for example, is the disproportionate share payments sent to academic medical centers to offset the higher operating costs sustained as a result of having a disproportionately high number of patients with low income (Dickler & Shaw, 2000).

ATHs must also cope with the challenge of providing care to many indigent patients as well as to many underserved patients (Cyphert, Colloton, & Levey, 1997). Roddy et al. (2000) report that by 2002, the BBA Medicare/Medicaid payment reductions to AMCs will be "15.5 percent, a reduction that is twice that for minor or nonteaching hospitals" (p. 227). Although the budget law has an impact on the income of all hospitals, AMCs are especially hard hit. The reduction in IME funding means decreased funding for administration and educating residents (Roddy et al., 2000). These reductions through the BBA suggest that the future of the ATHs may be precarious (AAMC, 1999).

Roddy et al. (2000) express further concerns for AMCs because the BBA does not give more resources to those AMCs with the best outcomes. Obvious negative impacts are that patients will be sent to hospitals whose outcomes are less successful and that physicians will have to spend more time in clinical work to the detriment of their research and teaching (Roddy et al., 2000).

Medicare has been the largest source of funding for graduate medical education (GME), but with the BBA, Congress attempted to change this policy by reducing the federal programs' funding for this purpose (Freburger & Hurley, 1999; Iglehart, 1999b). The budget law contained major Medicare reforms that affect GME (Weinrich, 1999; Davis, 2000). Wray and Sadowski (1998) outline the main provisions of the BBA's effect on GME payments. These include changes in methods for counting DME and IME residents, as well as changes in the formula for calculating IME payment and incentives to reduce the size of GME programs. Under the new law, the resident count is calculated through "a rolling-average approach that creates an incentive" for the healthcare facility to reduce the number of its residents "by delaying the impact of reimbursement

reductions" (Wray & Sadowski, 1998, p. 373). Furthermore, the new regulations limit the number of residents and the resident-to-bed ratio. The changes in the IME payment formula also reduce the amount teaching hospitals receive per resident, regardless of the change in the number of residents (Wray & Sadowski, 1998). Also, the BBA offered direct financial incentives to teaching hospitals that cut the size of their GME programs. The BBA reduces IME payments and reduces payments from private payers and Medicaid (AAMC, 1999a). In essence, the legislation has made clear to teaching hospitals that Medicare will no longer pay the costs of the growing number of residents (Wray & Sadowski, 1998). This per-resident payment system will further financially strain teaching hospitals (Wingo, 1997). According to Slifkin, Popkin, and Dalton (2000), "Medicare is the single largest payer providing explicit graduate medical education (GME) funds, with payments totaling nearly $6.5 billion in 1995" (p. 231). GME funding reductions by Medicare also have had a profound impact on rural training programs in that financial impediments are one of the greatest barriers to the establishment of community-based programs.

The Association of American Medical Colleges (AAMC), analyzing the potential impact of the BBA, estimated that by 2002 projected BBA Medicare payments would reveal "a cumulative loss of $45.8 million in Medicare support for a typical major teaching hospital" (Dickler & Shaw, p. 821). The reductions would have a negative impact on teaching hospitals with at least a resident-to-bed ratio of .25. Such reductions would seriously damage the ability of teaching hospitals to perform their special missions of teaching, research, and service to the underserved (Dickler & Shaw, p. 821).

Benjamin (1999) argues that the BBA's cuts in prospective payments to teaching hospitals "represents the biggest threat to the GME system" (p. 77).

Even though the BBA included changes in medical education that would provide better care in rural communities, it has not solved major problems (Crittendon, 1999). GME provisions that offer benefits to rural physicians are undercut because of the overall decreases in IME payments. Crittendon (1999) says that the cuts in funding reductions will keep resident training tied to urban hospitals. Maze (2001) states that small hospitals especially were affected adversely by funding reductions as mandated by the BBA of 1997.

The Growth and Impact of Managed Care

With the introduction of managed care in the 1980s, AHCs faced an even greater threat: managed care. *Managed care* refers to a wide range of plans for reimbursing caregivers, "plans where third-party payers attempted to control costs by limiting the utilization of medical services" (Ludmerer, 1999, p. 353). Through various plans, managed care groups developed methods of controlling physicians and hospitals with which they were associated. The major strategy was to cut the number of hospitalizations and to limit specialists (Ludmerer, 1999). The most financially controlling form of managed care is the health maintenance organizations (HMOs). Preferred provider organizations (PPOs) are less financially driven and less restrictive. More flexible systems include discounted fee-for-service. Because HMOs reduced the volume of patients and limited the cost of services, AHCs could no longer function as well as they had under the DRG, a set fee per case determined by the diagnosis of the patient (Ludmerer, 1999). In addition, their missions to educate and conduct research were

challenged by a need for increased charity care and a case combination of sicker patients, so the AHCs' operating costs rose about 30 percent over community hospitals' costs (Ludmerer, 1999; see Goldman, Neill, & Rosenblatt, 1997). AHCs received more indigent care subsidies and fewer private and third-party payments for patient care (Fredburger & Hurley, 1999). Price-conscious HMOs tried to avoid teaching hospitals because of their higher costs. In turn, as the number of admissions to AHCs began to decline and occupancy rates dropped, many teaching hospitals were forced to close beds (Ludmerer, 1999).

Managed care as a strategy of clinical practice can benefit academic medicine through its goals of emphasizing prevention, teamwork, and protocols; but in the absence of a "coherent financial system" to support the missions of AHCs, since the 1980s managed care has come to have a different meaning: "stringent price pressures driven by insurance plans competitively bargaining with hospitals" (Kuttner, 1999, p. 1095).

Benjamin (1999) states that managed care has cut costs significantly in non-teaching hospitals, with the result that private hospitals attract more patients who seek non-specialized services. In addition, insurers of managed care programs have started to decrease their contribution in such social goods as uncompensated care and GME (Benjamin, 1999).

The world of managed care challenges the AMC in new ways as it learns to compete with non-academic providers (Goldman et al., 1997). Freburger and Hurley (1999) view the biggest threat to academic health centers in today's market as the "proliferation of managed care and its attendant consequences" (p. 284). AMCs provide care that costs more and is less efficient than care provided by the private sector.

Another problem facing the AMC is that managed care companies find it difficult to impose their structure and goals on the AMC's organizational pattern and culture. Managed care companies, unlike most AHCs, want providers who see their patients as consumers. In addition, only limited data suggest that AHCs provide superior care or have sicker patients (Freburger & Hurley, 1999).

Some researchers (e.g., Campbell, Weissman, Moy & Blumenthal, 2001; Roddy et al., 2000; Ludemer, 1999) argue that managed care plans may actually steer enrollees away from AHC hospitals, as evidenced by decreases in the rate of inpatient admissions and in the length of stays for inpatients (Freburger & Hurley, 1999). Reuter and Gaskin (1997) reported similar trends in a study that analyzed hospital discharge rates from seven states in 1991 and 1994. The AHC hospitals were not as successful in attracting HMO patients as other hospitals. Managed care plans may also push down the prices for services at AHC hospitals (Fredburger & Hurley, 1999).

Managed care also threatens educational activities of medical schools by decreasing resources for resident training programs, especially the direct training of medical students and residents. Freburger and Hurley report that "1 to 2 years of additional experience is needed to prepare graduates of U.S. residencies for practice in a managed care environment" (p. 292).

Decrease in Research Opportunities

With the proliferation of managed care and the decrease in growth of patient care revenues for AHCs, the amount of research at teaching hospitals is decreasing. AHCs in markets that are saturated with managed care "have a reduced ability to cross-subsidize clinical research from patient care revenues" (Campbell et al, 2001, p. 805; see also

Ludemer). Even with external grants, the institutions are unable to recover the full costs of research. Managed care demands clinical productivity that does not allow investigators time for research (Freburger & Hurley, 1999). Results from a study conducted by Campbell et al. (2001) found that 9 out of 10 research leaders thought the receipt of less money for treating patients coupled with the necessity of making up that loss by seeing more patients was creating a moderate problem for clinical research that was growing ever larger. These perceptions were greatest among those located in areas highly affected by managed care. HMOs actually discourage patients from participating in research protocols because managed care often encourages patients to go to non-teaching hospitals (Freburger & Hurley, 1999). Ludmerer (1999) sums up the dangerous effect that budget-reducing pressures from managed care has on AHCs: "The main research and development unit of the American health care system – the academic health center – was being allowed to wither as cost-containing mechanisms designed for the hospital industry as a whole ignored its special needs and mission" (p. 357).

Jones (2000a) concludes that AMCs simply cannot do their job in the current marketplace because they cannot compete without sacrificing or harming their work in education, research, and outreach services. AMCs are urged to compete in the marketplace, but they are also "told to provide educated health professionals and research products to their competitors, and to take nonpaying patients off their competitors' hands"; however, "nongovernmental healthcare providers are not willing to directly pay for these 'public goods'" (Jones, 2000a, p. 291). Such traditional sources of funding as state appropriations, Medicare, and "cost-shifting of uninsured care services to paying patients, are rapidly drying up" (Jones, 2000a, p. 291). Similarly, Levey & Anderson

(1999) state that managed care organizations say that "healthcare is business, not a public service" (pp. 240-241). Wingo (1997) concludes that AHCs cannot have—as their single focus—the production of profit, because they are also bound by research and teaching missions. Market forces have thwarted AHCs with the marketplace's preference for cheaper providers and a limited pool of physicians, as well as the eradication of cross-subsidies, a mainstay in teaching institutions (Iglehart, 1998b). Kuttner (1999) observes:

> Medical schools and their affiliated teaching hospitals are being made to absorb shocks for a system that fails to acknowledge their unique role and compels them to turn themselves into essentially commercial enterprises that compromise their core mission, degrade their capacity to teach, and turn out graduates shorn of altruistic ideals. (p. 1092)

A crisis in funding has created a series of financially driven events that put PPPs and AMCs in competition when they should be collaborating. These gaps between the two groups and the path toward closing them have also been examined.

Robinson states relative to managed care (pg 26-27) that physicians want resources devoted to the care of their patients, not for other economic priorities in our nation. The role of the physician will always be as an agent for the patient.

Bullard (2001) and Kahushf (2001) identify the change in traditional healthcare delivery, and physicians who understand modern healthcare become activists for collaborative practices: "Business interests alone cannot continue to drive health care activities" (Bullard 511). Doctor Phelix Maroti-Ibanez, founder of MD Magazine, addressed a medical school class on what it means to be a doctor: (no affiliation of practice is identified) "to be a doctor is to be a whole man who fulfills his tasks as a

scientist with professional quality and integrity, as a human being, with a kind heart and high ideals, and as a member of society, with honesty and efficiency" (qtd. in Bullard). This statement suggests that we align and collaborate with our fellow health care professionals, be they in academics or private practice. A dual perspective is needed because in the training of new physicians, "university practitioners and independent practitioners can not substitute for each other" pg 780.

Gaps Between PPPs and AMCs

In light of the forces threatening our medical schools and academic teaching hospitals, how have private sector physicians remained disconnected from them? Understanding this disconnection is vital to developing collaboration between PPPs and AMCs. Baumann, Kerdel, Agrawal, and Kirsner (1999) studied the relationship between AMCs and community physicians. Among the barriers they discovered were hindrances to referrals, implemented by managed care companies. Although referrals from community physicians to AMCs do occur, private physicians who were queried thought the relationship could improve and both the educational and clinical agendas of each could be better served. Baumann et al. (1999) suggested open intraspecialty referral as a cost-saving bridge between PPPs and AMCs.

Gaps Between Curricula and Training Programs

Robbins, Bradley, and Spicer (2001) have suggested that the development of future healthcare leaders incorporate an approach that more closely integrates academic graduate medical education and practitioner training programs Their article, which reviews literature over four decades, describes a program in health administration,

focused on leadership, that relied on a set of competencies for training.It asserts such integrated competencies could help promote "collaborative efforts between academic and practitioner programs" (p.188). Having standard competency requirements provides a mechanism to promote collaborative efforts between academic and practitioner programs, efforts that can help pinpoint curricular gaps as well as enhance the development of healthcare leaders and professionals (Robbins et al., 2001).

Holm and Brogadir (2000) imply that the existing gap cannot be filled through partnerships unless the environment where the relationships originate has "mutual trust and feelings of shared destiny" (p. 8). Building such relationships is difficult given that private physicians and tax-supported institutional medical center physicians inhabit two separate cultures—but certainly with common ground (Holm and Brogadir, 2000).

Lister (2000) reports that large healthcare organizations and their graduate medical education programs can be "paralyzed by political infighting" when they get caught up in "operational issues" and "struggles for turf" (p. 109). He advocates the inclusion of PPPs in plans to change medical healthcare delivery, and he states that physicians must be ambassadors for radical change.

Bryan (2000a) writes that the professionalism of physicians is challenged by the tensions between physicians and the market-driven forces in healthcare delivery. He contrasts the wide gap between such values as altruism and humanism in medicine, on the one hand, and such capitalistic values as market-driven goals, stockholders' worries over personal dividend income, and basic consumerism, on the other. He states that a gap occurs in the institutional directives of academic physicians, and a gap occurs in the competition between academic physicians and private physicians. These gaps, along

with the disconnection between big business and the service and principles of most general medical practitioners, have contributed greatly to the culture conflict between corporate and private practice of medicine. Amid the complexities of this culture conflict, the ideal solution would include the realization that "government and business share a mandate to limit the societal burden of heath care costs" (Bryan 2000b, p. 429).

Reece (2000) quotes Jeff Goldsmith's concept of the gap between healthcare professionals and corporate officials. Goldsmith states:

> "The gap between professional and managerial cultures that existed during most of the 1980s and early 1990s widened into a chasm by the late 1990s. Professionals of all stripes—not merely physicians, but nurses, technicians, social workers, and others—saw their practices increasingly commoditized and marginalized by the growing corporate ethos in their systems; professionals lost contact, physically and spiritually, with the 'adminisphere'—the tiny handful of people running their systems." (p. 278)

Doctors need to look beyond the narrow spectroscope in serving their patients' best interests, retaining "the necessary degree of independence to be patients' advocates" (Chantler, 1999, p. 1181). They must participate "more fully in the problems that our society faces and in the health-care systems that we have developed" and "operate in a framework in which politicians, health-care managers, and indeed doctors themselves are more open and realistic with the public about what is possible and what is not possible . . ." (Chantler, 1999, p. 1181).

Cosgrove (2000) speaks of the "imperative for innovation" and, referring to thoracic surgeons, reports that residents are encouraged to avoid creativity and that this

discouragement, in addition to financial and other pressures, has "biased us against innovation" (p. 840). As part of his argument for innovation, Cosgrove quotes Abraham Lincoln's challenge to Congress (Dec. 1, 1862): "The dogmas of the quiet past . . . are inadequate for the stormy present. The occasion is piled high with difficulty, and we must rise with the occasion. . . . We must think anew and act anew" (p. 840).

An interview with a surgeon in Charleston, SC, based in a medical university town and in direct competition with the AMC where he is an alumnus, helped identify the gaps that he experiences in such a town-gown environment. His list includes such problems as the unwillingness of some academic leaders to collaborate with private-practice colleagues and their insistence on maintaining sole control of the training of new specialty physicians; the view by private practitioners that the operations of medical care at the university medical centers is highly inefficient and political, discouraging collaboration; and the view of private practitioners that financial disincentives discourage alignment with the medical schools because of their inherent bureaucracies, especially when it comes to the dispersion of funds to multiple sources with the institution.

Further, this surgeon identified deficiencies relative to medical school practitioners and also deficiencies or problems inherent in private practice: Medical school deficiencies included the unwillingness of some leaders within the institution to engender goodwill with private physicians; inefficiencies that require more employees to do the same job than a private-practice would require, resulting in greater financial waste; and bureaucracy and politics. Private-Practice deficiencies he included were economic pressures that keep PPPs from referring patients to sub-specialists in order to meet their own overhead costs, so that even when qualified through board certification, general

specialists, i.e., general surgeons, may be less willing to refer to sub-specialist surgeons (vascular, colo-rectal, endocrine, etc.). Even though the sub-specialists may have more experience in a particular area, a less experienced, though qualified, physician may subconsciously elect to perform a procedure out of financial motives. In essence, having too broad a practice—knowing a little about a lot, versus a lot about a little—is not always in the best interest of high quality, cost efficient care.

In the interview, the surgeon said malpractice and torte reform issues differ between the institutionally based practitioner and the independent private practitioner; institutions have limited liability as opposed to PPPs, who are more vulnerable to large suits. [include next sentence in this paragraph]Other differences include the fact that PPPs have less exposure daily to education. Also, PPPs cannot police their own, whereasinstitutionscan be less tolerant of incompetencies and poor practice habits. Other problems include having a multitude of individual practices in the community, requests from PPPs to hospital administrators to purchase new equipment, difficulties with scheduling, and favoritism. These kinds of problems create control issuesbetween the hospital administration and those who support new initiatives regarding graduate medical education.

Why have we allowed ourselves to reach the current state and, worse yet, to perpetuate it? Ideally we should hope to achieve a delivery system that values each participant, whether academic or private. AMCs and PPPs must be jointly accountable for the present and future state of physicians from training to formalized practice.

Little in the literature reflects this disconnect between AMC and private physicians. Most articles that comment on this division do so in nonspecific ways and

tend to use such abstractions as "the greater public good," (Vinson 1994) "leadership," (Robbins 2001), "from advocacy to ambassadorship" (Lister 2000), "medical education reform" and "Medical education and Society's Needs" (Maudsley 1999).

Competition between the sectors—AMC and private practice physicians—wastes valuable resources in the duplication of services and increased inefficiencies. This division within our profession greatly affects the community of patients we serve and its elected leaders, who ultimately make financial decisions relevant to dispersion of resources.

Gap Between Professional and Managerial Cultures

One of the other contributors to the obvious gap between academic medical centers and PPPs lies in the tensions between professionalism and commercialism imposed by our marketplace. Bryan (2000a) contrasts the traditional values of the medical profession with values of commercialism. Among the traditional values, Bryan lists patient service, advocacy, altruism, and empathetic care, suggesting that what is best for the patient is emphasized over all. In contrast, capitalistic values represent profit, competition, services driven by the market, responsibility to stockholders, and consumerism. Hence, a culture conflict occurs between the motives driving business versus those driving the direct care of the patient.

If our premise is that healthcare costs are disproportionately high as a percentage of our GNP, wouldn't it make sense to sacrifice self-interests for a more cohesive structure for all aspects of healthcare delivery, including the formal GME training? The gap between AMCs and PPPs begins in medical school. Some medical students have a prevailing mentality that spending one's entire time in medical school and graduate

education at institutions of higher learning—revered facilities that have trained physicians to practice their livelihood at the forefront of medical knowledge and expertise—is excellent; yet many of them justify an abrupt transition into a competitive clinical setting or private practice across the street from the institution that trained them, unwilling to involve themselves in their parent institution's mission. Medical culture must own this division as a problem, a distinctly separatist view, before collaboration can develop. If positive change is to occur, all must yield to the greater good single-mindedly with shared responsibility and shared destiny. The gap is basically one of perceptions.

Since its beginning the gap between professional and managerial cultures has actually widened (Reece, 2000). Reece (2000) notes that in the growing corporate ethos, professionals lost contact with the "adminisphere." This cultural chasm between the corporate and medical worlds leads to paranoia. The basis of any partnership or collaboration relies on "mutual trust and feelings of shared destiny that are engendered by the environment in which the relationships are forged" (Holm & Brogadir, 2002, p. 8). Physicians functioning within their own realm of practice become beholden to the business perspectives of respective leaders.

Anderson et al. (1998) state that although physicians are primarily responsible for patients, organizations control the fiscal decisions of healthcare so that the challenge becomes "healthcare integrity versus business accountability" (p. 97).
Medical schools and graduate medical education programs must rely on practice dollars as a major source of income. Hence, there is an internal drive to compete for patients and bring these dollars into their respective institutions. However, teaching hospitals ultimately train their own competition. "Private practice physicians perceive that

competition from academic center faculty is unfair in the sense that fulltime faculty are subsidized in part by tax dollars. Full-time faculty perceive that they must engage in private practice to maintain their skills, that their practice is rendered inefficient by the university's competing demands, that they (like private physicians) pay steep overheads, and that they are unfairly singled out since all physiciansare in competition.

MacLeod (1987) states that community physicians can influence university boards of trustees, hospital boards of trustees, legislatures, alumni associations, and potentially university administration to perpetuate self-interest.

Collaboration as a Solution

Although the literature is only now beginning to speculate about ways in which AMCs and private-practice physicians could collaborate, some patterns are emerging that have potential for the development of a model.The literature mentions some models for collaborating and alludes to possible goals achieved by this kind collaboration in four major areas. Ultimately, these four areas are going to affect the outcome of healthcare delivery: (1) cooperation among physicians in private practice and AMCs; (2) improved research and more cost-effective research; (3) better care of under-served patients;and (4) greater impact on legislators and others who formulate public policy affectingmedical care.

In addition to improving collaboration among medical practitioners, the public must be educated. The public misunderstands the roles, problems, and opportunities in each of these sectors of medical practice. Public education programs must be developed to rectify this apparent lack of knowledge at the national, local, and individual levels. Not only should we educate ourselves about the current state of healthcare affairs and

avoid the complacency of which Kotter speaks (qtd. inWaldhausen, 2001), but we must educate the public about such efforts towardconsensus and the fulfillment of the joint missions in healthcare shared by PPPs and AMCs.

Legislators too must be educated. Dolan (2000) comments on the importance of educating legislators on the effects health policy initiatives have on health care providers and the patients they serve. Furthermore, alumni of medical schools do not seem well-informed about the affairs of the medical center and its opportunities for a relationship with PPPs. This vision must begin with a thorough knowledge of the business climate and how best to effect organizational structure. Waldhausen (2001) refers to Harvard Business School's John Kotter, who states that complacency, lack of vision, and the lack of coalitions are common errors that can thwart efforts toward organizational change. Neither group, private practice nor academic physicians, has passionately pursued or even explored all the possible options for collaboration. After all, the marketplace drives them toward competition. Bryan (2002b) envisions a well-unified collaboration between private practice, part-time faculty and full-time medical faculty so that they would form a "seamless unit—the ideal of a unified profession" (p. 429).

Affiliations as a Solution

Affiliations among physicians and between physicians and other groups could be part of a collaborative model for change. For example, they might involve affiliations with schools of business for medical leadership training in business. Friedrich (2002) identifies such a program for medical educators through the Harvard Macy Institute. His focus is on training physician scholars in "best" educational practices, includingan understanding of the economic, legal, and management aspects of integrated health care.

Affiliations offer opportunities for cohesive action to motivate growth and influence legislative and health policy initiatives. A healthcare system speaking with one voice fosters advocacy, engenders more universal support, and endows its members with the power to influence the industry for the greater good. Collective actions of a unified group outweigh individualism in the creation of a new culture (ref?).

Partnerships

In articles discussing potential partnerships between AMCs and PPPs for mutual benefit, organizational models appear that better position AMCs and community providers of healthcare in today's turbulent healthcare environment, helping them conserve resources and providing more efficient organizational structure in the face of imposed market and governmental constraints (see Weiner, et al., 2001). Wolff and Maurana (2001) state that in establishing community academic collaborative partnerships, the community identified important themes for such a relationship to be conceived and remain sustainable: "(1) creation and nurturing of trust; (2) respect for a community's knowledge; (3) community-defined and prioritized needs and goals; (4) mutual division of roles and responsibilities; (5) continuous flexibility, compromise, and feedback; (6) strengthening of community capacity; (7) joint and equitable allocation of resources; (8) sustainability in community ownership; and (9) insufficient funding" (p.166). Boex and Henry (2001) discuss community-academic collaborative partnerships in terms of risks vs. benefits.

In terms of physician recruitment, a community-partnership program at East Tennessee State University, funded by W. K. Kellogg Foundation, brought about changes within both the medical school and the rural community it served (Goodrow, 2001).

Graduates of this program were more likely than their non-program peers to select their practice in a rural location. Prior to this program little interdisciplinary teaching or collaborative research had occurred. In analyzing this collaborative program, Goodrow (2001) says that the program led to stronger ties between the medical professionals and the community, a more effective curriculum, wide-ranging faculty development, sharpened skills among health professionals, and better health for people in the area served by the center.

A three-decade study of partnerships between AMCs and private physicians found changes in educational methods and attitudes. The study suggests training physicians will require the development of innovative opportunities beyond the walls of the AMC (Nash and Veloski, 1998). [no new paragraph]Omenn (1999) says that partnerships are important in helping AMCs and PPPs improve healthcare in their communities. AMCs and PPPs are obliged, under a social contract, to care for their local and regional communities and to raise the standard of healthcare in the community (Omenn, 1999).

There is much literature about collaborative training opportunities for primary care physicians training in rural settings, but it suggests few specific opportunities for specialty (surgical) training in such a setting, away from the parent institution. It is well known that rural training programs help to retain and even increase the numberof physicians settling in rural communities near hospitals (Slifkin, Popkin, & Dalton, 2000). Rabinowitz and Paynter (2002) state that medical students should work in both urban communities and rural settings. Not only can they see the difference in the kinds of rewards afforded by each kind of practice, but also they can gain a broader range of experience with medical problems that vary between AMCs and particular communities

(Schafer & Shore, 2001). Perceptions of such rural private practice programs as reported by Norris (1993), in an era with increased physician extender services (nurse practitioners and physicians assistants becoming more prevalent in community-based medical practice), one would naturally question the patients' perceptions of such non-physician or physician-in-training contacts. Studies such as Norris's (1993) demonstrate rural patients' acceptance of resident trainees. Cooper, Johnson and Heller (1986) report on a collaborative method at the University of Kentucky Hospital, established to facilitate support of rural physicians.

Crouse, Norris and Wolff (1996) outline many benefits for physicians who participate in collaborative educational ventures: Preceptors may receive discounted or free continuing medical education sponsored by the AMC, access to esteemed clinical faculty, partner recruitment opportunities, and library/educational access. A level of personal satisfaction and status among one's peers may be a reward. One's medical knowledge base is advanced and ultimately the community's health should be improved. Hence, academic medical centers and those primarily responsible for GME have a broader outreach and exposure to new faculty expertise and opportunities for resident training.

One perspective mentioned infrequently in the literature is that of a role-model or mentor (see Seibert and Haq, 1999). Maudsley (1999), who speaks to societal needs and expectations of the medical education system and necessary reform, identifies the importance of example in teaching, especially with regard to ethical and professional values, and he claims that "the power of role models cannot be overestimated" (p. 144).

Education

Any model for collaboration between AMCs and PPPs must consider the role medical education must play.

Regarding professional development of physicians through continuing medical education, Bennett et al. (2000) conclude that collaboration among practitioners and institutions with leadership from medical organizations like the AAMC (American Association of Medical Colleges) AMA, American College of Surgeons, and some specialty organizations, "is essential to create the best learning systems for the professional development of physicians" (p. 1167). They state that, "The professional development of physicians is a life-long commitment that builds on formal and informal opportunities to learn emerging science, apply innovations and clinical settings, and expand understandings of caring for patients" (p. 1167). Frankford and Konrad (1998) report also on the integration of education practice and community in a market-driven era. They discuss initiatives to develop responsive medical professionalism through education and the utilization of clinical sites to train physicians. According to Frankford and Konrad, "The medical profession must recognize that traditional individualistic professional autonomy is no longer a viable path; in the face of market imperatives, professionalism can survive only if it is reformulated" (p. 144).

Levitt (1991) encourages traditional physician's practices outside of the major academic centers. He argues that a "symbiotic relationship", is advantageous to both PPPs and AMCs. Molinari, Ahern, and Hendryx (1998) discuss gains from public-private collaborations in terms of promoting community health. Collaboration can lead to lower health care costs, better allocation of community resources to improve the health

status of its residents, and an improvement of the standard of care (Molinari et al., 1998). Carney et al. (2002) further discuss the unique educational opportunities afforded by community-based interdisciplinary education. They explained "a collaborative model their school developed and implemented in 2000 to integrate institution- and community-based interdisciplinary education through a centralized office, the strengths and challenges faced in applying it, the educational outcomes that are being tracked to evaluate its effectiveness, and estimates of funds needed to ensure its success" (p. 610). They claim that such an endeavor "will allow us to be more responsive than reactive to the changes coming our way" (p. 620).

The literature about such collaborative programs in a surgical specialty, much less a surgical subspecialty like thoracic or cardiovascular surgery, is sparse. Given fewer numbers of practitioners with whom to gain consensus, it seems that these opportunities could be forged rapidly. The majority of articles reviewed on training opportunities for physicians in the community setting focus on the training of primary care practitioners, but little is reported on specialty and sub-specialty training in these settings.

Golditch (1998) argues that resident education is affected by managed healthcare because of the declining patient base and decrease in public funding for GME. He discusses options for increased resident educational experience including the placement of clinical and voluntary faculty in sites removed from the parent institution. Klint (2002) notes that "health care is the country's largest service industry and stands in a unique position different from the profit-driven entrepreneurial goals of other market segments. In developing and marketing unified ventures, we enhance the public's trust at a time when it seems to be on the decline." The public at large likely is misinformed

even about the differences between those who practice in a private physician groups versus those whose practice in large tax-supported institutions. After all given directives from managed care, insurance companies and the marketplace in general, academic medical centers have lost patients, therefore lowering their patient base at a time in which there is decreased public sector funding for graduate medical education. Competition within the same service delivery line, especially in the same local market, leads to duplication of services, less economy of scale and fragmentation. There is a sector of talent in the private community that has an affinity for academia and participation in fulfilling the mission of an academic medical center. If unity is agreed upon and chosen over the alternative, which is competition and fragmentation, then how can we best collaborate? A model should be developed that would allow for more interchange between faculty, educational exposure as a continuum of their practice, a prestigious title, research opportunities and personal growth. A major cause of concern for non-participants is the phenomenon of physician burnout, especially given these current turbulent times in health care caused by the strains imposed from decreasing reimbursement, rising malpractice insurance premiums, more governmental control, more conflict over bargaining for "contracted lives," legal entanglement and more. The level of cynicism among doctors today ishigh. Studies related to physician job satisfaction reported from the Physician Worklife Survey conducted through AHCPR agency as reported by Williams (1999). Linzer (2000) confirm the concerns imposed from isolation and individualism given our times. Williams (1999) notes that physician job satisfaction is linked to patient care and health system outcomes, making such a concern imperative. One could infer that an opportunity for change in the structure of graduate medical

education and practice could engender (DCA) stimulation, diversity and challenge. As a result of this study, existing surgical training curricula could be modified and the surgical work environment altered. Younger surgeons' expectations for practice after completing such rigorous training are not met. Strategies for survival and success in these uncertain times are discussed by Souba (1995). Souba (1999), after identifying many of the previously stated barriers to success in academic surgery, states that academic surgery is an evolution. Factors affecting academic practice include "reimbursement and referral patterns, the generation of clinical income, promotion and tenure guidelines, the importance of surgical research, and recognition of a life beyond academic surgery.... The business of medicine is not business; the business of medicine is medicine, and that includes teaching and research." In his article entitled "Reinventing the Academic Medical Center," Souba (1999), discusses the impetus for change, why change is so difficult and avenues for reinventing the future through teaching, research, patient care, and new business ventures (pg 119). Topping 1999 reports on the AHC's adaptive strategies for survival including networking (table 1),the implication is that "we as educators are not doing a good job of preparing our trainees to survive in today's turbulent wars." Other authors including Edgar (1999), Johnson (1993) and Green (1990) remark specifically on stressors to surgeons. It is inferred that much of this level of cynicism and burnout among practioners could be thwarted by collaborative models that are mutually beneficial to private practice, academic practioners and graduate physicians in training. Our legacy is at risk along with the care of our patients. Thorough knowledge of collaborative opportunities breaking down existing barriers is imperative.

Research

A collaborative model would also involve biomedical research, which is vital to advancing medical care and affecting patient outcomes. Frist (2002) states that progress in research relies on communication among all those involved: policy-makers, researchers, patients, and healthcare professionals. Frist (2002) also argues that research depends on collaboration within and between the federal government and private and nonprofit groups, considering the budgetary limits today. He also states that translating research into policy and practice will be difficult without more communication and collaboration. A member of the Senate Committee on Health, Education, Labor, and Pensions, Frist (2002) states that increased scientific research has made healthcare far better and has had a large positive effect on medical employment. Frist (2002) concludes that "the synergies borne of increased scientific collaboration also help translate research discoveries into practice" (p. 1724).

Research ventures that include not only tenured, academic faculty of AMCs or full-time researchers but also independent practitioners allow for joint involvement in clinical research between the academic researcher and the PPP. This joint involvement should afford the advantage of a larger patient base, more practical clinical research trials, subject retention, and intellectual stimulation. Ultimately the investigator becomes a better clinician. There is tremendous personal satisfaction awarded any clinician who makes a contribution to advancing medical knowledge (Smith 1991). Smith (1991) states: "Our laboratory is the community practice." He also states that continued research combats the "burnout" many physicians experience in their daily medical practice. Conti (1990) reports on a survey conducted by the American College of

Cardiology about its private practitioner members' involvement in clinical cardio-vascular research. His conclusion is that there is a need for such involvement and barriers must be overcome to achieve more practitioner involvement in clinical research.

Beck (2000) describes economic incentives for physicians to participate in clinical research trials both for their practice income and their patient outcome. Such advantages from clinical research participation include professional challenge and knowledge, opportunities for their patients to receive the latest treatment, and enhanced reputation as a cutting edge/state-of-the-art practice; therefore, both the quality of care and one's bottom line improve.

Programs must be developed that build partnerships and work across boundaries imposed by our affiliations in order to achieve the greater good- that of better health care, better health education, and a more self-sustaining health system for our state in the age of budgetary restraints. Our practices cannot exist in isolation, removed from centers of higher learning, research and the institutions responsible for training new physicians.

Tort Reform

One barrier to collaboration among physician groups is the legal difference between academic and private practioners. Tort reform for professional liability as commented on by Hammond (2002), Putrucci (1999), Alan and Fischer (1999) is in the best interest not only of all physicians but for industry and the public at large. Most people, whether in the health care industry or not, are unaware of such a barrier. A private physician represents a 'cash cow' to a trial lawyer, while limited liability judgments against medical university state physicians do not. Such frivolous legal activity also escalates the practice of defensive medicine and hence the cost of health care

delivery (Klingman 1996). Both AMA-backed legislation and federal tort reform initiatives for the deteriorating medical liability insurance climate are described by Albert (2002). Due to the "junk lawsuits" which are so prevalent and cause a risk for enormous verdicts, excellent physicians are being driven out of medicine and nothing is being done to improve patient care.

Petrucci (1999) reports on an encouraging movement generally unknown to most practitioners as the American Tort Reform Association (ATRA), an organization involved in state-torte reform initiatives. As a surgeon, Petrucci has served on their board of directors. With its legislative agenda, this organization has had an impact on 45 states and the District of Columbia. ATRA employs grassroots advocacy to achieve tort reform at the state level. Averting the malicious and costly activity of frivolous lawsuits is one of the major targets of this organization. Allen and Fischer (1999) state: "The reality is that this country is facing a crisis of litigation that threatens to dismember society, result in counterproductive redistribution of wealth, limit innovation, and make insurance difficult to obtain. In the medical setting, it leads to the practice of 'defensive medicine'" (14-15). ACS needs to educate its members and the public about the stranglehold that professional liability awards impose upon the daily practice of medicine and the enormous challenge that medical practitioners face in opposing the Trial Lawyers Association to achieve tort reform. However, until such a process occurs the collaborative efforts of practitioner groups in different sectors will be impaired.

Through organizations such as the American Hospital Association, grassroots advocacy networks are developed that can have an impact on the legislative process for change (http://www/aha.org/grassroots/advocacy/GRProcess.asp). Such efforts involve

advocacy initiatives through collaboration with "key contacts" within communities (http://www/aha.org/grassroots/advocacy/GRProcess.asp). The Grassroots Advocate Network states that federal health programs (Medicare/ Medicaid) "account for about half of the average hospital's annual patient revenues" (http://www/aha.org/grassroots/advocacy/Grgettingstarted.asp). Efforts achieved through grassroots advocacy actions, directed through state medical associations and up through the American Hospital Association, lobby vigorously to congressional representatives about the impact of federal budget cuts on the local level (http://www/aha/org/grassroots/advocacy/Gettingstarted.asp).

Many ideas about collaboration appear in the literature, and these, coupled with the primary research explained in Chapter Three, can aid in developing the best models to strengthen collaboration between PPPs and AMCs.

CHAPTER THREE

METHODOLOGY

The purpose of this project is to determine what models can be used to strengthen the relationship between PPPs and AMCs. This study hypothesizes that there are yet unexplored collaborative models between the academic and the community practitioner that foster a unity of the profession and a mutually beneficial partnership that would have lasting impact on unifying our existing medical structure and propelling future advances in education, research, and clinical care. This study consists of a formal qualitative survey of leaders in academic medicine, specifically focused on both academic surgeons and on private-practice physicians in South Carolina.

Design of the Study

This study has three major components: questionnaires, interviews, and observation.

Two 4-page questionnaires were submitted to randomly selected surgeons from both the community and AMC to obtain an assessment of opportunities for collaboration from the point of view of each group. The first questionnaire (see Appendices A-B) was targeted to individual South Carolina- based surgeons. It asks about various aspects of thesurgeons' relationships to AMCs as well as the relationship between AMCs and community physicians. The second questionnaire (see Appendices C-D) was targeted at administrators within the South Carolina AMCs and explores current roles played by

private practice physicians and possible fruitful collaboration. A letter from the principal investigator was sent along with each questionnaire. The letter stated the purpose of the study, the fact that it is for a study that partially fulfills the requirements for a Doctor of Health Administration (DHA) degree through the Medical University of South Carolina, the voluntary nature of participating in the survey, the options to refuse to answer any and all questions if the respondent so chose, and the protection of the confidentiality of specific respondents in any published materials. Two hundred and twenty (220) surveys were sent to academic chairs, and 217 were mailed to both surgeons in private practice and those responsible for the graduate medical training of surgeon candidates.

Questions for the qualitative surveys were generated both from experiential inquiry, review of current literature, and much pre-proposal exploration with all sectors involved with healthcare delivery, be they administrative or clinical. Questionnaire One (for private-practice physicians) elicits opinions regarding how the respondent views AMCs, level of interest in possible joint ventures with AMCs, interest in participating in graduate medical education, and other, yet unexplored avenues for collaboration. The questionnaire has 11 questions that require respondents to rank answers or check an option among four or five responses. It also has one open-ended question that asks respondents to write their positive and/or negative views of collaboration between private-practice physicians and those in AMCs. Questionnaire Two (for department chairs and program directors of AMCs) has 12 questions structured similarly to those in the first survey.

Lastly, the principal investigator personally interviewed six physicians/surgeons several of whom [three] have their primary role now in an administrative position.

Among these physicians are current administrative physician leaders in the Greenville Hospital System, while others have roles primarily in the private practice setting. Two of the physicians interviewed practice outside the Greenville, South Carolina, health care market. One, who practices in Charleston, made a transition from academia to private practice in the state of South Carolina and yields a unique perspective having made such a transition. He has the unique perspective of having worked in both settings. The other physician practicing outside Greenville's healthcare service is a renowned thoracic and cardiovascular surgeon with extensive academic and clinical practice credentials spanning decades;he also has assumed the highest regarded leadership position in national surgical society organizations. He spent a sabbatical year away from clinical practice to attend and a Master's of Public Administration at the Kennedy School of Government at Harvard University, and thus can provide a unique perspective as both an extensive clinical practitioner and healthcare administrative leader. The instrument uses a standard set of questions, much like the American College of Surgeons and the American Medical Association, to obtain respondents' perspectives on how private-practice physicians in AMCs may collaborate from a policy and financial perspective. This was an open-ended personal interview with individual AMC leaders and PPPs in the state of South Carolina.

While the results of interviews were anecdotal rather than quantitative, they clearly point out major problems and collaborative solutions.

This data was used to explore positive and negative attributes and attitudes of constituent groups regarding collaboration with the ultimate purpose of adding value to private practices and engaging in the mission of the AMCs—and hence the cause of

medicine. Interviewees are identified only by job title. These survey and interview results are examined to develop models of collaboration that might develop between AMCs and PPPs.

Analysis of Data

The survey analyses qualitatively evaluate the data collected. Data management was done by a statistician working independently from the principal investigator. The principal investigator was not informed about the identity of respondents; this information was maintained by The Department of Research until the returned surveys were determined to be sufficient for analysis, at which time the key to identities was destroyed.

Analysis of the interviews gave insights into perspectives of respondents regarding the AMCs' roles in today's healthcare delivery system, financing of education for future physicians, and opinions about both current and potential models for collaboration with PPPs. These data are provided in Chapter Four and Chapter Five.

CHAPTER FOUR

RESULTS

Survey results borne out through this research indicate that private practice physicians are only minimally engaged in the mission of our AMCs.[a]

To elicit opinions, the researcher submitted two quantitative surveys that were mailed to two groups. Group I represented private practice-community based surgeons (thoracic, cardiac, and vascular surgical specialists),a group the researcher thought would be like-minded in their perspectives, types of practice, discipline, and schedules. The second group surveyed were academic healthcare leaders, hospital administrators, and academic surgical department chairpersons who are charged with administrative duties at AHCs. The researcher also conducted in-depth interviews with six physicians and administrative leaders, some of whom are also surgeons and academic leaders. These interviews also supported the conclusion that there is minimal engagement between AMCs and PPPs.

General Statistics

Two-hundred and twenty (220) questionnaires were sent to the administrator group in South Carolina. Similarly, 218 surveys were mailed to surgeons practicing in South Carolina. The names were obtained from multiple sources including the South Carolina Hospital Association, the directories of The Medical University of South Carolina and the University of South Carolina School of Medicine, the South Carolina Medical Association, hospital administrators, and the state surgical societies. Attached to

each survey was a cover letter explaining this research (see Appendices A & C). Each survey contained 12 questions (see Appendices B and D). Respondents mailed their completed surveys to an independent statistician, who analyzed the responses question by question and tabulated the results. These results were blind, and the researcher, who received only cumulative responses, had no contact with those who answered the survey. Each survey was numbered for tracking purposes only, and the statistician was the only person with access to the respondents' names. Several weeks were allowed for responses between the receipt of the survey and its return. Since the return was very high from the first mailings, no second mailing or notice was sent. The number of responses from t the program directors, department chairs, and hospital administrators was 71/220. The number of reponses fromthe thoracic, cardiac, and vascular group was 116/218. The statistician submitted cumulative totals. Appendices A-D provide the cover letter and survey questions for each of the two groups.

The research identified several primary barriers to collaboration between PPPs and AMCs. It also identified potential solutions that would help formulate collaborative models to support the training of future and present healthcare providers through such avenues as research, state-of-the-art clinical care, and education.

Survey Results from Program Directors, Departmental Chairs, and Hospital Administrators

Question One asks each group to identify its level of involvement with AMCs. Seventy (70) percent of the AMCs now use PPPs to teach or have done so within the last five years. Of those who did not use private physicians, 25 percent said they had used them, and 30 percent have not used them at all.

Question Two asks how many PPPs participate in the AMC's program. Seventy-one (71) percent reported using four or more private physicians; 13.7 percent had four to eight PPPs, 15.7percent used nine to 15 PPPs, and 70.6percent engaged 16 or more.

Question Three asks about the level of involvement by PPPs. Sixty-one (61) percent have limited or no involvement, and only 38.8 percent demonstrated extensive participation.

Question Four probes the relationship of administrative leadership with private practice physicians. Of the respondents, 33.3 percent provided volunteer service while 64.7 percent were compensated for their efforts. Further breakdown shows that the primary reason for an AMC using private practice physicians was teaching only.

Question Five explores PPPs' credentials that warrant their selection by an AMC in their graduate medical training program. Of the PPPs, 30.8 percent were given an annual review of their credentials and performance whereas 69 percent received review in the range of two to more than five years, a result suggesting the need for more stringent quality assessment.

Question six investigates the specifics of private physicians' academic roles. Results revealed that 54.9 percent supervised residents in regularly scheduled rotations, 38 percent supervised residents infrequently, 29.5 percent gave regularly scheduled lectures as part of the teaching program; 49 percent gave occasional lectures; 30 percent helped review medical student applicants, resident candidates, and faculty candidates. None participated in tenure and review decisions, a result suggesting near total disengagement from faculty-directed decisions. Twenty-one (21) percent of PPPs participated in clinical research studies as investigators, and 31 percent referred patients

for clinical trials. Seventy-four (74) percent of the private practice physicians, however, either sought consults for patient care from AMC faculty or ultimately referred complex patient cases for management by AMC faculty colleagues. This level of involvement, consultation and referral to AMC staff by private practice physicians should foster more rather than less collaborative efforts between the two groups. Only 12.6 percent of the state's private surgeons polled advocated or lobbied for AMCs with politicians and other decision-makers on behalf of the institution. Since the private surgical community is larger both in number and potential influence, this statistic is dismal. The only other roles of the PPPs in faculty position besides clinical care were their attendance and participation in teaching conferences such as M&M (morbidity and mortality), grand rounds, and continuing medical education programs.

Question seven explores the major barriers to collaboration between PPPs and AMCs from an administrative prospective. Eleven (11) percent reported having no interest in collaborating. In order of perceived relevance from major barriers to the least perceived barriers, (1) PPPs were viewed as competitors; (2) administrators could not afford to compensate private physicians to teach in their program; (3) PPPs were rarely interested in participating in the programs; (4) coordination of compensation and review of credentials for PPPs were too time-consuming; (5) communication was perceived as poor between PPPs and those administrators who might be interested in collaboration; and (6) they expressed concerns about the competence of PPPs to teach in their programs. Comments in response to the open-ended question related to time constraints on private physicians and financial constraints from the administrators.

Question eight surveyed the major incentives for collaboration with PPPs from an administrative perspective. The order of relevance of issues from the major incentives to the least perceived incentives was: (1) a wider variety of clinical experiences available to graduate medical education students; (2) education for GME students possibly could be improved through training in private practice settings; (3) cost savings could be provided to the residency programs; (4) patient care could possibly be improved by drawing on a larger clinical faculty experience; (5) teaching burden on full-time faculty could be decreased; and (6) the number of investigators participating in clinical research studies could be increased. Comments in response to the open-ended question were primarily that community and medical staff support for graduate medical education could be improved.

Question nine asked whether those administrators surveyed feel that avenues for collaboration between PPPs and AMCs were being fully exploited. Eighty (80) percent of respondents said that potential avenues for collaboration between PPPs and AMCs were not being exploited.

Question 10 assessed perceived mutual benefit of collaborative opportunities between PPPs and AMCs from the administrators' perspective. Seventy-nine (79) percent reported teaching, 73 percent reported clinical care, and 76 percent reported community service as the perceived benefits of collaboration. Research was the least perceived avenue for mutual benefit, as Table 1 shows:

Table 1

Administrators' Perception of Benefits from Collaboration

	Teaching	**Clinical Care**	**Research**	**Community Services**
Strongly agree	40.8%	32%	19.7%	32%
Agree	38%	40.8%	25%	43.6%
Not sure	2.8%	7%	38%	16.9%
Disagree		4.2%	9.8%	2.8%
Strongly Disagree			1.4%	

Question Eleven asked for administrators' views regarding key participant groups used to foster collaborative efforts between PPPs and AMCs.

Results are shown in Table 2.

Table 2

Key Participant Groups for Collaboration

Role for Group	Academic Medical Centers	Private Practice Physicians	State Government	Federal Government
Lead Role	81.6%	12.6%	5.6%	8.4%
Major Role	12.6%	70%	26.7%	28%

Minor Role		9.8%	54.9%	47.8%
No Role		1.4%	4.2%	8.4%

The data indicate that 95 percent of AMCs have or should have a significant role as the key participant group. Also a majority of the administrators (83 percent) said that PPPs should have the lead role or major role as the key participant group directing collaboration. These results demonstrate that no clear participant was defined as a standard. Nearly equal percentages reported that AMCs should have the lead role and relegate activity to the PPPs and that AMCs should control the activity of collaboration with PPPs. A unanimous response was that there is no significant role for state or federal government.

Survey Results from Thoracic, Cardiac, and Vascular Surgeons

Question One addresses the level of involvement of practicing surgeons with AMCs and the extent of the affiliation. Responses are ranked from not much contact to the specifics of each participant's involvement. Of those responding, 38percent have little or no contact with the AMC, and 41 percent of the respondents' only contact is patient-referral based. Hence 79 percent of private practicing surgeons are not involved with their affiliate AMC. However, 27 percent utilize the AMC for their own continuing education. Thirty-nine (39) percent do have an active role in educating medical students and/or residents. Only 21.5 percent participate as an investigator in clinical trials or research projects. Importantly, only 11 percent of practicing surgeons advocate for funding and/or governmental support to influential persons or governmental bodies on

the AMC's behalf. These findings reflect no strong tendency for participation from community-based surgeons in the missions of an AMC.

Question Two explores the level of clinical patient care referrals to AMCs from private practice surgeons. Seventy-three (73) percent of respondents seldom or never refer patients to AMCs. Fifteen (15) percent regularly (once or twice per month) refer patients and 12 percent routinely (more than twice per month) refer patients to AMCs. This impliesdisengagement for which any number of reasons could account; i.e., competition, lack of respect, cost or operational efficiency, quality of care in comparison to the private practice setting, etc.

Question Three examines participation in one's own continuing education at the AMC and responses are scored as to the level of involvement occurring from "never" to "more than twice per year." Again, a large percent of respondents, 57 percent, seldom or never participate in their own continuing *affiliate* medical center. Essentially this finding implies that once the majority of AMC graduates leave, they are truly gone and remain disengaged. Forty-three (43) percent attend a continuing education symposium in the AMC once or more than twice per year.

Question Four similarly scores respondents on the amount of time spent in the *active* role of educating medical students and/or residents from the AMC. The time includes both classroom and didactic training as is shown consistently above. Fifty-four (54) percent seldom or never educate graduate medical students or trainees. Forty-five (45) percent do play an active role once to more than twice per year.

A component of Question 4 asks whether an academic appointment is granted the private practice surgeon. A majority (57.7 percent) of practicing surgeons do have an

academic appointment, whereas 45.6 percent have no academic appointment. The academic appointments are reviewed at various intervals from "never" to "as often as once a year," and respondents report 42.5 percent of their academic appointments are reviewed once a year. Some 37.5 percent are reviewed from "every two years" to "less then once every five years." Twenty (20)% of the surgeons with academic appointments never have their credentials reviewed. This response to the above question of academic status among practicing surgeons, a benchmark traditionally for a "higher standard and achievement," is granted only about 50 percent of the time. Last, only 25.8 percent of respondents are compensated for their participation in the teaching program, leaving 74.2% uncompensated.

Question Five investigates practicing surgeons' level of involvement in clinical trials or research studies. Consistently 77 percent of those responding seldom or never participate in the research mission of an AMC. A mere 22.8 percent of those responding are involved once to more than twice per year in such investigation.

Question Six addresses the advocacy issue from the practicing surgeon's support through funding and/or governmental influence to supplement the mission of the AMC. Seventy-four (74) percent of those answering seldom or never advocate either for funding and/or governmental support for academic centers. Advocacy for a medical center to support its mission can be achieved through contacts with influential persons, governmental bodies, or local, state, or national avenues such as medical societies and associations. Only 2.7 percent advocate for funding, 13.8 percent advocate for governmental support, and only 11 percent advocate either to influential people or governmental bodies.

Question Seven seeks opinions regarding opportunities for collaboration between private practice physicians and AMCs that are not being exploited. Interestingly, 88.4 percent agree or strongly agree that there are opportunities for collaboration between private practice physicians and AMCs. Only 10.6 percent are either not sure or disagree with the possibilities of collaboration with mutual benefit to both parties.

Question eight seeks opinions regarding collaborative opportunities that from the practicing surgeon's perspective would be of mutual benefit to both groups, as Table 3 shows:

Table 3

Collaborative Opportunities for Mutual Benefit to Both PPPs and AMCs from the Practicing Surgeons' Perspective

	Teaching	Clinical Care	Research	Community Service
Strongly Agree	**51.7%**	**38.7%**	**25.8%**	**34%**
Agree	**38.7%**	**43%**	**41%**	**45.6%**
Not Sure	**5%**	**15.5%**	**23%**	**14.6%**
Disagree	**.8%**	**1.7%**	**1.7%**	**.8**
Strongly Disagree			**.8%**	

The majority of respondents agrees or strongly agrees that all categories designated in Table 3 would be of mutual benefit to both groups. Specificially 91 quiered believe that teaching and 82 percent that clinical care would be mutually served through more intensified collaboration. Interestingly, a similar majority (67 percent),also

believesthat research would serve the same positive outcome, and 80 percent even believe shared work in our community could result in the same outcome. This table clearly shows a significant minority of respondents report either uncertainty or disagreement in each category queried for mutual benefit. The responses to this question clearly demonstrate a commonality of perspective regarding the mission of teaching, clinical care, research, and community service in the healthcare provision that we all are trained in and serve.

Question Nine takes the collaborative initiative between private practice physicians and AMCs and explores the importance of key participant groups in enhancing these mutual efforts. The participant groups identified for this question include: (1.) AMCs (as part of their teaching, clinical, and research missions); (2.) private practice physicians (as they refer patients, seek continuing medical education, or participate in training medical students and residents); (3.) state government (as it exercises responsibility for healthcare of its citizens); (4.) federal government (as it exercises responsibility for healthcare policy and execution at the national level), as Table 4 shows.

Table 4

Roles of Key Participant Groups in Enhancing Collaboration Between PPPs and AMCs

Role for Group	**Academic Medical**	**Private Practice**	**State Government**	**Federal Government**

	Centers	Physicians		
Lead Role	68.9%	18%	2.5%	3%
Major Role	23%	67%	29%	26.7%
Minor Role	.8%	6.8%	46.8%	41%
No Role			12.9%	21%

Ninety-two (92) percent of those responding believe that AMCs should have a lead or major role in the initiatives toward collaboration while 85 percent believe the private practice physicians should also have a lead role. Sixty (60) percent of the respondents do not feel that state government should play a role in collaborative initiatives. Likewise, 62 percent responding do not believe the federal government has any significant role to play in such initiatives between AMCs and PPPs. Hence, the directives toward more formalized collaborative models between practicing surgeons and AMCs with the goal of enhancing and supporting an AMC's mission and a fostering of efforts toward overall better healthcare must be formulated by either the AMC or community surgeon leadership. Which of the two groups is to take the lead role is the question, and clearly by the respondents' account no one party is felt to take that lead role.

Question 10 asked the respondents to rank the major barriers to collaboration between practicing physicians and AMCs. Six (6) percent of those responding stated they had no interest in developing collaborative efforts between the groups. Regarding the major barriers, the most significant was, "I lack time (due to existing commitments) to engage in collaboration." Next in order of significance is, "I lack the knowledge about existing programs," followed by, "Academic Medical Centers are unwilling to pay for

volunteer faculty time." The least significant barrier to collaboration is, "I'm not sure about its value for me." Other written responses included:

- Malpractice concerns
- Personalities
- Attitude differences
- No key model or structure in place to implement such programs beyond the medical student resident role, i.e., fellowship opportunities
- Hostility arising from turf protection
- AMCs want our paying patients, but not our unfunded patients
- Help students to be boarded out of town
- AMCs need a clear mandate to responsibly spend needed tax dollars
- Distance to AMCs
- Highly competitive local market
- Competition for referrals
- No forum in which both are represented and we are able to able to develop collaboration
- Locally negotiate terms of collaboration
- Personal enrichment other than CME
- Patient or client acceptance—especially research studies
- Opportunities are not presented for research collaboration
- AMCs usually are not interested in private practice physicians. They would rather hire their own.

Question 11 asks those surveyed to rank the major incentives to collaborate between private practice physicians from the perspective of the practicing thoracic, cardiac, and vascular surgeons. These are ranked in order from the most important to the least important regarding these major incentives: (1.) access to continuing medical education; (2.) improved patient care by giving a larger referral base of specialists; (3.) improved education for medical students and other allied health professionals through training in the private practice setting; (4.) participation in teaching; (5.) added value to my practice, capabilities through participation with medical students and residents; (6.) cost/financial benefits provided to my practice; (7.) participation in research; (8.) exposure to potential recruits for my practice. Written in comments included the following:

- Broader voice/clout to effect change
- A vital pool of talent lies in the private practice of medicine, which is not tapped into for graduate medical education (especially in our tight financial times). There is much to be gained by win-win—collaborative opportunities.
- Removing incentives to compete is to the detriment of patient care.
- To give us a vehicle to provide the best patient care for our patients and to be our patients' advocates
- Idea exchange with other specialists

Question 12 requests additional comments from those surgeons surveyed as to whether they would participate in collaboration for mutual benefit between private practice physicians and AMCs. Additional comments were encouraged with regard to any aspect of this question that was important to the respondent. Both positive and

negative comments were welcomed. The comments were so numerous, helpful, and rich that they are incorporated as further documentation.

In-depth Interviews

Comparative to any qualitative assessment of a premise is an open-interview forum that could yield through such exchange perspectives for assessment beyond that provided in a written instrument. Thus several key community physicians and administrative leaders, some of them who assume the role of practicing surgeon and academic leader, shared during interviews that their ideas and attitudes were openly probed through informal uninterrupted dialogue. These individuals were randomly selected with no preconceived notions of what they would say, and they were a diversity of personality types whose perspectives would be broad and realistic.

Listed under the name of each person interviewed is a list of his major observations. **Hospital Chief of Staff (former AMC faculty currently in private practice. Comments are based on experience at one AMC.)**

- AMC lacks a maturity level regarding a vision for private practice involvement.
- Private practitioners can be allies and support MUSC endeavors.
- AMC is focused on growth at any expense.
- AMC's infrastructure is massive and complex.
- The provision of legal relief, i.e., tort reform, is vital to spare local community doctors from the incumbent risk of training residents.
- PPPs remain an untapped source.

Vice President at South Carolina Hospital System and vascular surgeon:

- There are three arms to this problem of graduate-medical training: 1) the government is ultimately the source of monies and legislation; 2) there is a physical intermediary between corporate business and the providers, i.e., the insurance companies; 3) providers are the hospitals and the doctors practicing within them.
- The providers (hospitals and doctors) form the "core business" of medicine.
- We are in an era of economic tightening"
- We must create opportunities for MD involvement and find avenues for physicians to partner with hospitals.
- AHCs reside typically in urban areas where access can be difficult for those in more removed communities or locales.
- AHCs are losing disproportionate share dollars, indirect and direct medical expense dollars, and ultimately losing patient volume. Therefore they are unable to compete as well in the economic environment established by managed care directives which dictate more cost-effective and efficient service.
- Healthcare is a "local" business.
- Many community hospitals are located in the urban areas and therefore position themselves where most AHCs are established, i.e., metropolitan areas.
- AMCs must form alliances.
- Some form of taxation through an all-payer bill could support medical training.

Surgery Chairman, South Carolina Hospital System and vascular surgeon:

- A dualistic system and missions are not in the best interests of advance. We must have a "blended" mission. The interviewee's private hospital is one that incorporates the academic and community service mission.
- AHCs have a social responsibility for perpetuating the knowledge and skill base surgeons acquire.
- We must have a sense of community.
- Medical education cannot be delegated.
- There are key rewards of private physician service to academic medical centers: a) increased professional satisfaction through such service; b) less physician burnout; c) elimination of a dualistic system.
- Focus of the private sector is a) reimbursement issues are principal concern; b) private physicians are essentially independent businessmen and that is their marquee; c) many private physicians' revenues may be encroached upon by their participation in training resident surgeons.
- Healthcare expenditures are on the rise.
- We should no longer be fragmented within small groups of private practitioners whose self interest and welfare of their own practices are supreme.
- Third-party payers also pick apart private sector and academic physicians and facilitate competition.
- A blending of the two practice settings, i.e., town and gown, into a "conglomerate" fosters: a) a raising of the level of healthcare provided—the patient is the custodian of the bar; b) indigent patients are equitably

distributed; c) all participate in the education of future MDs; d) profits continue to support a joint mission; e) the strengths of both sectors are drawn upon.

- Thus, a "hybrid model" is formed.
- Physicians have a hard time policing themselves and therefore standards set through collaboration eliminate such issues.
- A unified voice and leverage is fostered through collaboration.
- Professional satisfaction arises through academic pursuits and involvement.
- Involvement by the private sector creates indebtedness and goodwill. Compensation should be provided to improve the desire to have community surgeons participate in academics.
- Then at the end of the day, overall quality is improved and healthcare is at a higher standard.

Surgeon, formerly in private practice, and Vice President of a South Carolina private hospital:

- If the program from and in which one receives his or her training does not instill in you the desire to return or give back to that mentor institution, then we, the AMCs, have failed.

A thoracic surgeon and former president of the Society of Thoracic Surgeons:

- The keys to success are: a) establish a political agenda; b) have business acumen; c) identify successful leaders who are impassioned and fervent in these efforts.
- The healthcare system enterprise has been transformed into "big business."

- There is no reason to have such dichotomy in our medical practice.
- Much of the problem with healthcare arises from the makeup of our legislative bodies, which primarily are big businessmen and lawyers.
- There are key representatives with medical degrees in the legislature, such as Dr. Greg Gansky, MD (Iowa) and Dr. Bill Frist, MD (Tennessee).
- Coordination through organizations that represent the face of our profession—such as The Society of Thoracic surgeons.

Pediatric cardiologist, PPP and AMC adjunct faculty:

- If there were no financial problems, would this division between town and gown still be as much of an issue?
- Medical education can be perceived as a burden or privilege.
- The educational experience in the private sector is different than in an academic setting and aids in the checks and balances that equalize the bias and interests of the academic side.
- PPPs as board members of AMCs creates a healthy balance.
- Medical university hospitals were initially chartered for the purpose of educating and training doctors.
- AMC has distanced itself from the private community, not the other way around.
- Collaboration establishes opportunities for long-term cohesive practitioner relationships, which are important trends for the future. Trust is built through these relationships.

- Access by patients and physicians alike to the most qualified, skilled physicians and latest technologies is improved through such relationships.

These interviews as well as the results of the questionnaires support the hypothesis presented here and suggest that steps should be taken to incorporate PPPs into the work of the AMCs.

CHAPTER FIVE

DISCUSSION

The barriers to collaborative models between private practice physicians and AMCs are admittedly complex. The focus of this research has been directed toward developing collaborative strategies to foster or perpetuate more active involvement of PPPs in the mission of AMCs.

The research indicates that many practicing surgeons concur that their future survival in such a high-cost and high-expectation healthcare market could be improved by better collaboration between AMCs and PPPs. Otherwise, they continue to be part of the divisiveness and erosion of the centers of learning that we share. Clearly, gaps exist in the goals of PPPs and AMCs in their delivery of healthcare. The agendas that guide PPPs and AMCs are different and seemingly in opposition to one another.

A Proposed Model for Collaboration

In order to bring together the two separate cultures, narrowing the gap between PPPs and AMCs, it is important to address initiatives in the areas of Education, Clinical Care and Research that involve both AMC's and PPP's in ways that are mutually beneficial .This approach has, perhaps, the best chance to break the competitive cycle created by the economic crisis in a medical market driven by business models. The challenge to health care providers, health care leaders and ultimately to the patients, is to formulate and implement a model for effective collaboration between our academic health centers and their own offspring, i.e. the private practice community based

physician. Nearly 500 health care providers were surveyed and many conclusions can be reached to construct a collaborative model for mutual gain.

The data indicate that viable options exist that can be drawn together to formulate a model of collaboration. The initiatives in a plan for collaboration can be organized as follows:

Education

1. Develop affiliations with schools of business for medical leadership training to better understand the economic forces and how to managethem.

2. Establish a dedicated alumni base (specialty specific) for local, regional physicians who would be willing to participate in GME opportunities. In return these regional physicians would receive discounted fees for GME, closer access to academic clinical faculty, opportunities to recruit partners, access to the library and to such educational opportunitiesas grand rounds, teaching conferences, and visiting professors from premiere AMCs.

3. Establish a Central Physician Support Liaison Office to keep a registry of alumni (speciality specific) who coordinate a preceptorship program and engage the PPP in the various roles of educator, researcher, and clinical care provider.

4. Provide an information exchange system with updates regarding health policy and legislative initiatives to foster advocacy and cohesiveness.

5. Coordinate support for legislative efforts

6. Coordinate efforts to influence tort reform and other medical/legal initiatives

7. Establish a forum to help physicians, especially those at mid career, who are affected by burnout through interchanging the educational continuum of the practice in order to combat cynicism.

8. Establish scholarships, endowments, and trust funds for education and research or funding of GME programs by private sources focused on collaborative programs that benefit both the AMCs and PPPs.

9. Provide opportunities for faculty sabbaticals through partnerships with the private sector.

10. Provide access to graduate medical education in administration and medical management through scholarships.

11. Develop a hierarchy of opportunities requiring different levels of participation from PPPs (even low levels of participation are positive).

Clinical care

1. Sharing of medical technology among AMCs and PPPs.

2. Draw on expertise of colleagues for advice with difficult cases.

3. Improve patient referrals between AMC physicians and PPP's.

4. Improve access for PPP's patients to the most recent specialty procedures.

5. Improve community outreach through programs that cover indigent patients providing access to AMC resources.

6. Provide public awareness of the fiscal and legal sides of medicine.

7. Establish mentorships that team seasoned PPP practitioners (e.g. surgeons) with residents outside of the AMC.

8. Improve the public image for both PPPs and AMCs in the context of these new collaborations.

Research

1. Allow PPPs and physicians from AMCs to develop combined practices, thus serving a broader spectrum of patients.

2. Develop a program to increase participation of PPPs in funded research programs.

The basis of this and subsequent proposals should be a mutually beneficial partnership arrangement with the goal of advancing the mission of our AMC along with the impact of their various products, i.e. future MD's, while promoting the knowledge and skills of the private sector physician participants. The data from this study indicate that collaboration should focus primarily around education and clinical care. The

initiatives above may provide ways to transform "competitive" strategies between PPPs and AMCs into "collaborative" strategies. If collaboration is to happen, PPP's must take on aspects of both the teaching and clinical care mission. Based on the survey results, the task of aligning these goals of creating mutual benefit for the PPP and AMC is centered around teaching.

"Perhaps the greatest challenge to the efforts to improve thoracic surgery resident education is the pressureof the current health care environment which does not reward the teacher" (reference Seminars in Thoracic and Cardiovascular Surgery-pg 176, July 1998 volume 10 #3.)

"We must move from a competitive orientation that exists in each of our chosen fields and exists toward our "own kind" (i.e., other members of our own specialty whom we view as competitors for patients and thus health care dollars) to a position of mutual respect, support, and professional cooperation." (reference- Annals of Thoracic Surgery, 1998: volume 65 pg 905-908)

Each initiative recommended above is likely to be a complex problem. For example improving involvement of PPP surgeons is complicated as discussed below. From the surgeons surveyed, it is interesting that PPPs involveed in AMC mission (79 percent) have little contact with AMC staff, yet many receive their CME credit via an AMC. To the detriment of the AMC, only 11 percent of the PPPs advocated funding for AMCs. Also a majority (73 percent) of PPP surgeons do not send patients to AMC's. Credentialing and recognition for such PPP participation is scant at best, yet academic appointments are held in high esteem. Given the importance of degree recognition and AMC affiliation, consideration should exist for alternative tenure arrangements for

affiliate faculty. Interestingly, the majority of PPPs seek involvement with the AMC, but the avenue hasnot yet been created.

The directives for collaboration must come from joint participation (AMC and PPP) in formulatinga template and thus a model for mutually beneficial collaborative efforts. Government or governing bodies cannot be relied upon to identify our own assets at the local and state levels and be expected to implement a structured program.

This review reveals that the model should be formulated jointly with equal representation from selected AMC and PPP leadership and exist so as to benefit both participant groups and ultimately our patients and the advance of medicine. Though barriers certainly exist, the level of interest, willingness, and identifiable incentives weigh large. The model should center initially around teaching and clinical care interchange. The financial, institutional, and personal incentive concerns must be addressed jointly. Mutual ground is more than ever necessary as is evident from these survey results.

PPPs and AMCs must prioritize their mission-based strategies for delivering efficient and effective delivery of services. Overlaps in the strategies of each group should be identified and developed into concrete plans for collaboration. The survey results clearly indicate that there is some overlap in medical education. This is an area for more meaningful collaboration. Many "action strategies" and ultimately "collaborative models" can be proposed from the research provided in this study. We must seek to achieve alignment of purpose, strategy, processes, and outcomes if we are to drive closure of the many "gaps" between our two positions for medical practice—those in the AMC with a defined mission of education, clinical care, and research and those in

the practicing community setting who at least believe in their medical institutions and their purposes (Anderson, 1998). All practitioners need to advance their own education, are mandated to provide high quality medical care, and engage in either the review or active participation in research activities—all toward the advancement of their own as well as their community's healthcare delivery.

Surgeons, be they academic AHC surgeons or community-based surgeons, are guided by ideal norms, standards of practice, and values that the profession upholds. Commitment to excellence in the practice of the profession and to the preservation and enhancement of the knowledge gained from institutions of higher learning is paramount.

It is incumbent upon all healthcare leaders, whether in administrative/ leadership roles or clinical positions, to invest the profession and the next generation of healthcare providers" (ACHE Newsletter, Fall 2001). Medical students' exposure during the graduate medical education process is broadened through invaluable experiences such as those attained through mentorship programs, community or private practice surgical rotations, or simply the exposure attained through perspectives of practice in a community setting. Lifelong role models that can dictate future practice patterns are potentially provided in such settings.

In reflecting on his own experience at the Medical University of South Carolina and beyond at centers of renowned academic graduate medical education, the author finds it very disturbing that, having received his entire medical training and skill sets at an AHC, he could begin practice in the private sector and have virtually no contact with the institution that trained him and many others as practitioners or is currently training colleagues in the same specialty.

As recently stated in JAMA (Jan 2 2002, vol 287,1, 113), "For medical students contemplating practice location, as with deciding on specialty choice, real world clinical experiences and role models facilitate decision-making and allow student to evaluate their own practice, lifestyle, and financial needs in order to obtain a broad-based foundation, students should consider obtaining clinical experience in both urban and rural settings." The medical profession is first and foremost concerned with genuine high quality patient care. Much of this is learned through effective tutelage and mentorship in graduate surgical training. Surgical knowledge and technical skills, combined with moral and ethical behavior patterns provide the essence of surgical practice aimed toward the restoration of health and preservation of life, all components founded on learned patterns through graduate medical school experiences. Surgical trainees will emulate the behaviors of their mentors. Moral values of the surgical instructors will influence the character development and expertise of their trainees.

Consensus was reached throughout the research on several levels. A majority of AMC leaders polled (70 percent) would like to utilize PPPs for teaching, yet only about 38 percent of the PPPs are involved in this aspect of graduate medical training. Obviously a disconnect is revealed. It is evident from the survey results that PPPs are not used extensively in the surgical training process at the graduate level. Many reasons exist for such patterns, including compensation, time allocation, motives of one's individual practice, and competition for the dollar, etc.

Respondents confirm that little compensation is available to the PPP sector and thus many community physicians have chosen to avoid the hassles inherent in the demands of such efforts. The rewards of mutual exchange have an impact on the value a

trainee sees for future practice, expansion of current knowledge and skill levels, along with academic achievement through research and appointment. Many of these factors are not fully realized by the private sector.

The different structure and organization of our competing healthcare delivery markets, i.e., academic vs. PPP, also leads to further separation in initiatives, practice styles, and focus. Different cultural perspectives also exist in the two environments. The practitioner's knowledge and clinical expertise is on a continuum and no one instructor or even institution can fully complete that process.

In order to help bridge the gap, critical planning factors must be reached through consensus building with key leaders from each sector, especially in a new and constantly changing healthcare environment manifested by expanded technologies, competitive pricing, and decreasing reimbursement, yielding significant financial constraints. Collaborative models can be formulated and their implementation achieved. The conflicts between AMC and PPPs can be resolved and yield pragmatic, functional, efficient results.

This research concludes that although barriers exist between AMC directives and those of the PPPs, these are surmountable given the conclusive interest by both parties evident in the survey results for such collaborative initiatives. Misperceptions about practice interests and generalizations have historically paralyzed the two cultures and thwarted many potential achievable practice initiatives to complement each other's skill sets, all for the good of advance.

Recommendations

An integrated strategic plan addressing the need for the directives of more active engagement of PPPs in the mission of an AMC can certainly be achieved as the commonalities and beliefs of the two parties are not too entirely distinct. A typical risk-benefit and cost-benefit analysis of such collaborative efforts should be undertaken. A suggested format would be to arrange an arena of credible, authoritative representatives from each side to examine the common perspectives identified through this research. Key leaders from academe and selected community physicians can develop an institutional structure and collaborative model for education, clinical care, and research. This model would foster unanimity across party lines for mutual gain.

As awareness of these issues to those of us practicing in the healthcare environment is vital, so too our findings and beliefs need to be imparted to local, state, and even national political leadership, as much of our financial support for GME is dependent on the political process. Interviews can be arranged with key legislators involved with health policy to hopefully have an impact on their understanding of this aspect of our healthcare crisis. Directives from the "battlefield" through key leadership can yield major changes with new visions and policy initiatives.

This can be accomplished through Working with and through such currently functioning organizational bodies as the American College of Surgeons, the American Medical Association, the Association of Academic Medical Centers, and various leading specialty-driven organizations, such as the Society of Thoracic Surgeons, Southern Thoracic Surgical Society, all of whom the researcher interviewed by telephone. Positive

input was received through these interviews and a unanimous belief in the initiative was identified.

Physicians and surgeons belong to the "collective" medical profession, i.e., a bigger entity than individual pursuits. As quoted by John F. Kennedy, "It is time for a new generation of leadership, to cope with new problems and new opportunities for there is a new world to be won."

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APPENDIX A

LETTER TO ACADEMIC MEDICAL CENTER LEADER

240 Oak Meadow Lane
Simpsonville, SC 29681
November 6, 2002

Dear Academic Medical Center Leader:

As you know, growing risks to healthcare resulting from shrinking resources and growing demands are challenging physicians and other healthcare professionals to explore solutions on many fronts. As a practicing cardiothoracic surgeon, I am well aware of the growing complexities in healthcare delivery and the importance of relationships within the medical community. This complex growth has led me to conduct a research project in partial fulfillment of requirements for the Doctor of Health Administration & Policy at the Medical University of South Carolina in Charleston. To complete this study I need your help.

This study examines the relationships and potential positive collaboration between the private-sector physician and academic medical centers.

If you could find just five minutes to answer the enclosed brief questionnaire, you would make an important contribution to my study.

Your answers will be confidential: your identity will not be matched with your answers. The questionnaires will go directly to a statistician, who will analyze the responses. The questionnaires are numbered only for purposes of tracking the return rate.

Please return the completed questionnaire (in the enclosed envelope) to the statistician by November 25. If you have questions about the questionnaire or the study, please telephone me at 864-455-6800.

Sincerely,

Douglas C. Appleby, Jr., M.D.

APPENDIX B

Survey for Program Directors, Departmental Chairs, and Hospital Administrators

Introduction

The Balanced Budget Act of 1997 has had a profound financial impact on academic medical centers' ability to fulfill their mission over the last several years. This survey is part of a study assessing ways to improve collaboration between private practice physicians and academic medical centers for mutual benefit. Your participation in this survey would be greatly appreciated.

Your answers are anonymous; we have numbered the questionnaires in order to estimate response rate. Your questionnaires will go directly to a statistician and Dr. Appleby will not know your identity.

This survey should require no more than 5-10 minutes.

Q1. Does your institution use Private Practice Physicians to teach residents?

☐ Yes ☐ No → Q1a. If no, did your program use private practice physicians at any time over the last five years?

☐ Yes ☐ No **(go to Q7, p.2)**

Q1b. If "Yes," the reason(s) the program ended are:

☐ Cost too much
☐ Quality of teaching was not satisfactory
☐ Overhead and Administration too burdensome
☐ Private practice physicians lost interest
☐ Other_____

Q2. How many private practice physicians participate in your program(s)

☐ 1-3
☐ 4-8
☐ 9-15
☐ ≥16

Q3. Please check the block that best describes the level of participation by private practice physicians in your department's teaching program

☐ a. We have no private practice physicians **(please skip to Q7, page 2)**
☐ b. Private practice physicians play a very limited role in our program (<5%)
☐ c. Private practice physicians play a limited role in our program (5-24%)
☐ d. Private practice physicians participate extensively in our program (25-49%)
☐ e. We rely heavily on private practice physicians in our program (≥50%)
☐ f. Other _____

Q4. Which of the following options best characterizes your program's relationship with private practice physicians?

- ☐ a. All work on a strictly volunteer basis (no payment)
- ☐ b. Some are compensated; some volunteer ------→ What percent are paid?____%
- ☐ c. All clinical faculty are compensated

Q5. How would you best characterize private practice physician credentialing?

- ☐ a. Appointments are reviewed annually
- ☐ b. Appointments are reviewed every 2-5 years
- ☐ c. We rarely review appointments (> every 5 years)

Q6. Which of the following activities are parts of your private practice physician faculty's role (check all that apply)?

- ☐ a. Supervise residents in regularly scheduled rotations through their office
- ☐ b. Supervise residents in infrequent rotations through their office
- ☐ c. Give regularly scheduled lectures as part of the teaching program
- ☐ d. Give lectures occasionally for the teaching program
- ☐ e. Help us review faculty candidates
- ☐ f. Help us review resident candidates
- ☐ g. Help us review medical student applicants
- ☐ h. Participate in tenure and review decisions
- ☐ i. Participate in clinical research studies as investigators
- ☐ j. Refer patients for clinical trials
- ☐ k. Supervise medical students who routinely rotate through their office
- ☐ l. Seek consults from regular faculty for patient care
- ☐ m. Refer patients (complex cases) for management by faculty colleagues
- ☐ n. Advocate or lobby for you with politicians and other decisions makers on behalf of the institution
- ☐ o. Other role(s) _____

_____

_____

_____

Q7. The major barrier(s) to collaboration between private practice physicians and academic medical centers from your perspective is (are) (**Check a. if you have no interest in collaborating with private practice physicians**)

a. ☐ I have no interest in developing collaboration (**skip to Q9**).

(Rank from 1 [biggest] to 6 [smallest])

_____Private practice physicians are rarely interested in participating in our program

_____We have concerns about the competence of private practice physicians for our teaching program

_____Private practice physicians view us as competitors
_____We cannot afford to compensate private physicians to teach in our program
_____Coordination of compensation and review of credentials for private physician are too time-consuming

_____Communication is poor between private practice physicians and those of us who might be interested

_____Other (write in) _____

Q8. The major incentive(s) for collaboration between private practice physicians and academic medical centers from your perspective is (are):
(Rank from 1 [biggest] to 7 [smallest])

_____Improved patient care by drawing on a larger experience base
_____Wider variety of clinical experiences available to our residents and medical students
_____Increased number of investigators to participate in clinical research studies
_____Decreased teaching burden on full-time faculty
_____Cost savings provided to your residency program(s)
_____Improved education for medical students and residents through training in private practice settings
_____Other _____

The following questions ask your opinion – please select one answer.

Q9. There are opportunities for collaboration between private practice physicians and academic medical center activities that are not being exploited.

- ☐ a. Strongly Agree
- ☐ b. Agree
- ☐ c. Not Sure
- ☐ d. Disagree
- ☐ e. Strongly Disagree

Q10. Collaborative opportunities that would be of mutual benefit to the private practice physician and academic medical centers, from your perspective, exist in:

(Check one answer in each column)

	Teaching	Clinical Care	Research	Community Service
Strongly Agree				
Agree				
Not Sure				
Disagree				
Strongly Disagree				

Q11. If we wish to enhance the collaboration between private practice physicians and academic medical centers, it is important for us to understand the roles of key participant groups. From your point of view identify the role for:

1. Academic medical centers (as part of their teaching clinical and research missions)

2. Private practice physicians (as they refer patients, seek continuing medical education, or participate in training medical student and residents)
3. State Government (as it exercises responsibility for healthcare of its citizens)
4. Federal Government (as it exercises responsibility for healthcare policy and execution at the national level)

(Check one answer in each column)

Role for Group	Academic Medical Centers	Private Practice Physicians	State Government	Federal Government
Lead Role				
Major Role				
Minor Role				
No Role				

Q12. Please write additional comments or suggestions you may have on how private practice physicians can collaborate and enhance the academic medical center's ability to perform its mission. Please comment on any aspect of this question that is important to you from your perspective. Both positive and negative comments are welcome.

Research _____

_____

_____

_____

Teaching _____

_____

_____

_____

Patient Care _____

_____

_____

_____

Community Service _____

_____

_____

_____

APPENDIX C

Responses to Question 12 in the Survey for Administrators

Question Twelve sought both positive and negative additional comments on or suggestions about how PPPs can collaborate and enhance the AMC's ability to perform its mission. This question was from the perspectives of the program directors and administrative leadership groups.

Research

Positive responses were

- Clinical outcomes and health economic studies
- Participation in clinical trials
- Increased patient base for research opportunity
- Potential profit for PPPs if their projects for collaboration are carefully chosen
- A larger patient base for study and help to validate and subsidize research if PPPs were involved in research
- Active participation by Academic community hospitals in clinical trials through coordinating research centers.

Negative responses to this question included:

- Decreasingly available time for each of the parties to engage in clinical research

- Unwillingness of many physicians to work in research only if their incomes are enhanced
- Lack of time to provide support—and not get paid for it. They would rather have personal time rather than engage in volunteer research. Many commented that there was nothing in it for them.

Teaching

Positive responses include:

- Experience with the practical aspects of medicine not fully taught at Opportunities for use of clinical trials, especially in areas such as oncology
- Importance of sharing patients between AMCs and private physicians in clinical trials, for a number of reasons.
- Addition of a substantial patient volume by PPPs to assist in high quality clinical research with the institutions' administrative and financial support.
- the AMCs, providing residents and students invaluable "real world" perspective with private community-based surgeons
- Experience from a private-practice perspective on healthcare delivery
- The inclusion of other vital healthcare providers beyond the MD group to offer "real world" experiences in the private setting. Private MDs would participate (a) because it makes them feel good to mentor; (b) the mentoring may eventually result in referrals to their practice.

Negative comments include:

- Compensation for private practice physicians' time
- Given decreasing reimbursement why expand one's work responsibilities
    - Collaboration is decreasing (and demands for payment are increasing) as private doctors experience increasing expenses and decreasing income. If they are on a production system, they refuse resident involvement as
- Compensation
- Selection of the best clinicians and provision for rewarding their participation
- Use of clinicians as teachers, therefore keeping clinicians up to date with high quality healthcare delivery

Negative comments include:

- Decrease in the number of physicians who view medical education as an opportunity to contribute to a greater good
- The major obstacle of federal reimbursement ("teaching physician billing") guidelines for PPPs, who might otherwise be interested in teaching residents
- The possibility that some willing doctors are terrible teachers or are negative about many aspects of a surgical profession
- No mechanism for compensation
- No or little recognition

Patient Care

Positive responses include:

- More exposure for trainees and more eyes on the patient should lead to better patient care.
- Assume care of an appropriate portion of the poorly funded and indigent patients.
- Future opportunities for practice opportunities exist through exposure to both private and institutionally based surgical practice.
- Working together may be more possible in the surgical area than in other specialities.
- typically students "slow them down."
- I believe primary care should be taught in the community and tertiary care at AMCs. AMCs typically want to "do it all and control it all" and this mindset drives a competitive wedge between AMCs and private doctors.
- Recognize that academic centers depend upon paying patients as well to subsidize their bottom line

Community Service

Comments included:

- What could we jointly provide in a service/learning approach?
- Training future healthcare providers to ensure future excellence in healthcare
- More and more require compensation

- The Free Clinic movement, which is rapidly expanding, is an excellent model for practicing physicians, FPs, Internests, and Subspecialists to participate in the community.
- Communicate the needs. We need more participation from both groups!
- If we all contributed ten percent of our time, there would not be so many problems with the uninsured, poorly medically educated, etc.
- Five to ten percent of private physicians are good about helping with community service.

Additional Comments

- In Charleston, we have a history of close ties and conflict. Conflict around competition for patients—close ties around student/resident education. We can do better!
- We have had extensive experience with the community trying to encourage involvement. Most private physicians choose private practice because they do not have an interest in being involved in academics. I appreciate this. The physicians that are willing to be involved generally feel they deserve something for their time and involvement—either service (the resident as a physician extender) or money, or both. At the end of the day most academic centers—private physicians see this as a business deal. Over the past ten years, this attitude has intensified.
- In this day and time, there is very little "goodwill"—quite sad. "Town-gown" issues will continue to be a problem nationally as the competitive

nature of these two groups persists. In my view, this is simply the way it will continue to be. While strong leadership by both groups can construct a collaborative effort, one must be aware that relationships will always be transient and often strained—Arabs and Jews—MacDonalds and Burger King—Coke and Pepsi, etc., etc.—

APPENDIX D

LETTER TO THORACIC, CARDIC, AND VASCULAR SURGEONS

240 Oak Meadow Drive
Simpsonville, SC 29681
November 6, 2002

Dear Surgeon Colleague:

As you know, growing risks to healthcare resulting from shrinking resources and growing demands are challenging physicians and other healthcare professionals to explore solutions on many fronts. As a practicing cardiothoracic surgeon, I am well aware of the growing complexities in healthcare delivery and the importance of relationships within the medical community. This complex growth has led me to conduct a research project in partial fulfillment of the Doctor of Health Administration degree at the University of South Carolina Medical School in Charleston. To complete this study I need your help.

The study examines the relationships and potential positive collaboration between the private-sector physician and academic medical centers.

If you could find just five minutes to answer the enclosed brief questionnaire, you would make an important contribution to my study. Both your positive and negative responses to these questions will be valuable to my research.

Your answers will be confidential: your identity will not be matched with your answers. The questionnaires will go directly to a statistician, who will analyze the responses. The questionnaires are numbered only for purposes of tracking the return rate.

Please send the completed questionnaire (in the enclosed envelope) to the statistician by November 25. If you have questions about the questionnaire or the study, please telephone me at 864-455-6800.

Sincerely,

Douglas C. Appleby, Jr., M.D.

APPENDIX E

Survey for Thoracic, Cardiac, and Vascular Surgeons

Introduction

The Balanced Budget Act of 1997 has had a profound effect on academic medical centers over the last several years. This survey is part of a study assessing ways to improve collaboration between private practice physicians and academic medical centers for mutual benefit. Your participation in this survey would be greatly appreciated.

Your answers are anonymous; we have numbered the questionnaires in order to estimate response rate. Your questionnaires will go directly to a statistician, and Dr. Appleby will not know your identity.

This survey should require no more than 5-10 minutes.

Q1. Please check all blocks that describe your involvement with the academic medical center with which you affiliate

- ☐ a. I do not have much contact with an academic medical center
- ☐ b. I refer patients to the academic medical center and communicate mostly about such referrals
- ☐ c. I participate in my own continuing education at the academic medical center
- ☐ d. I have an active role in educating medical student and /or residents from the academic medical center
- ☐ e. I participate as an investigator in clinical trials or other research projects
- ☐ f. I advocate for funding and/or governmental support to influential persons and/or governmental bodies
- ☐ g. Other _____

Q2. I refer patients to the academic medical center and communicate mostly about such referrals (check one)

- ☐ a. Never
- ☐ b. Seldom (less than once a month)
- ☐ c. Regularly (once or twice per month)
- ☐ d. Routinely (more than twice per month)

Q3. I participate in my own continuing education at the academic medical center

- ☐ a. Never
- ☐ b. Seldom (less than once per year)
- ☐ c. Regularly (once or twice per year)
- ☐ d. Routinely (more than twice per year)

Q4. I have an active role in educating medical students and/or residents from the academic medical center including classroom and didactic training.

- ☐ a. Never **(skip to Q5)**
- ☐ b. Seldom (less than once per year)
- ☐ c. Regularly (once or twice per year)
- ☐ d. Routinely (more than twice per year)

Q4a. Do you have an academic appointment?

- ☐ a. Yes
- ☐ b. No (**go to Q4c**)

Q4b. If yes, how often is your academic appointment reviewed?

- ☐ a. Once a year
- ☐ b. Once every two years
- ☐ c. Once every 3-5 years
- ☐ d. Less than once every five years
- ☐ e. Never

Q4c. If yes, are you compensated for participation in the teaching program?

- ☐ a. Yes
- ☐ b. No

Q5. I participate as an investigator in clinical trials or research studies

- ☐ a. Never
- ☐ b. Seldom (less than once per year)
- ☐ c. Regularly (once or twice per year)
- ☐ d. Routinely (more than twice per year)

Q6. I advocate for funding and/or governmental support to influential persons and/or governmental bodies.

- ☐ a. Never
- ☐ b. Seldom for funding (less than once a year)
- ☐ c. Regularly (once or twice per year) for funding
- ☐ d. Often for funding (more than twice per year)
- ☐ e. Seldom for governmental support (less than once a year)
- ☐ f. Regularly for governmental support (once or twice per year)
- ☐ g. Often for governmental support (more than twice per year)
- ☐ h. Advocate to influential people
- ☐ i. Advocate to governmental bodies
- ☐ j. Other _____

The next 3 questions ask your opinion. Please check one box for each question.

Q7. There are opportunities for collaboration between private practice physicians and academic medical center activities that are not being exploited.

- ☐ a. Strongly Agree
- ☐ b. Agree
- ☐ c. Not Sure
- ☐ d. Disagree
- ☐ e. Strongly Disagree

Q8. Collaborative opportunities that would be of mutual benefit to the private practice physician and academic medical centers, from your perspective exist in:

(check one answer in each column)

	Teaching	Clinical Care	Research	Community Service
Strongly Agree				
Agree				
Not Sure				
Disagree				
Strongly Disagree				

Q9. If we wish to enhance the collaboration between private practice physicians and academic medical centers, it is important for all of us to understand the roles of key participant groups. From your point of view identify the role for:

5. Academic medical centers (as part of their teaching clinical and research missions)
6. Private Practice Physicians (as they refer patients, seek continuing medical education, or participate in training medical students and residents)
7. State Government (as it exercises responsibility for healthcare of its citizens)
8. Federal Government (as it exercises responsibility for healthcare policy and execution at the national level)

(Check one answer in each column)

Role for Group	Academic Medical Centers	Private Practice Physicians	State Government	Federal Government
Lead Role				
Major Role				
Minor Role				
No Role				

Q10. How would you rank the major barriers to collaboration between private practice physicians and academic medical centers?

[Check a. if you have no interest in collaborating with an academic medical center]:

a. ☐ I have no interest in developing collaboration (**skip to Q 12**).

(Rank from 1 [biggest] to 5 [smallest])

_____I lack knowledge about existing programs
_____Academic medical centers are unwilling to pay for volunteer faculty time
_____I lack time (due to existing commitments) to engage in the collaboration
_____I'm not sure about the value of such collaboration for me
_____Other (write in) _____

Q11. How would you rank the major incentives to collaborate between private practice physicians and academic medical centers from your perspective?

(Rank from 1 [most important] to 9 [least important]) .

_____Improved patient care by giving a larger referral base of specialists
_____Access to continuing medical education
_____Participation in teaching
_____Participation in research
_____Added value to my practice capabilities through participation by medical students, and residents

_____Cost/financial benefits provided to my practice
_____Improved education for medical students and other allied health professional through training in private practice settings
_____Exposure to potential recruits for my practice
_____Other (write in) _____

Q12. Please write additional comments you have on whether you would participate in collaboration between private practice physicians and academic medical centers. Please to comment on any aspect of this question that is important to you from your perspective. Both positive and negative comments are welcome.

APPENDIX F

Responses to Question 12: Thoracic, Cardiac, and Vascular Surgeons

- The major barrier I would foresee is the conflict over control of the clinical revenue generated by private and academic surgeons. The "Dean's Tax" and "Chairman's Tax" typically come out of the surgery revenues for distribution to the less well compensated departments. Successful systems will find a way to preserve control of clinical revenue to the clinician who generates this revenue.
- 1 would be interested in helping teach medical students/residents. I don't know of any such programs in my community.
- I would be interested in private/academic collaborations.
- Academia needs private practice for volume in training. Private practice is slowed down with teaching, i.e., less efficient, not as attractive to private practice; if not it must be reimbursed some how.
- 1 am an employee of an academic medical center. I am an advocate for private practice physician participation. Questions 10 and I 1, what I perceive to be important, are not important issues for private practice physicians.
- Collaboration must improve between academic medical centers and private practice. Unfortunately, in many cases, the day a resident completes his or her training, he or she becomes an active competitor with the individuals/center that trained him or her. Each has a role to educate the next generation(s) of surgeons without access to significant revenue and funded patients. Increased collaboration

could result in mutual research projects, improved clinical care and far better resident education.

- Yes, I would welcome collaborative opportunities to be more actively engaged in the mission of AMC and thus both advance my practice knowledge and ability and further assist our medical training systems, training that is so vital to our future as health care providers.
- This is a difficult area due to decreased resources and reimbursement rates that would slow down the practice of non-academic physicians. Collaborative relationships that allow patients access to subspecialty care and research opportunities should be maximized.
- This questionnaire is written from a private practice perspective, so it is hard for academic physicians to fill out, especially items 10 and I 1.
- Show me a way that's mutually beneficial; I'm willing to consider it.
- Funding (lack of) has pushed competition to the point that referral is uncomfortable. Academic medical centers are seen as competitors without clear guidance as to their public service responsibilities.
- Yes, I would participate of the opportunity was mutually beneficial.
- There are lots of barriers both within practice as well as financial concerns. Time away from family. But could all be overcome.
- I would participate in such collaboration. I think it is extremely important to both as outlined in #1 1.
- 1 would definitely participate. The only way for us to influence the practice of medicine is through this type of collaboration.

- Finance and egos are major problems preventing collaboration. MUSC and Roper both have had plans in recent years for extending cardiac services. As long as there are enough financial resources for everybody to have his own kingdom, there is little incentive for give and take, which is necessary in a collaborative effort.
- Good idea. Good for all.
- I have practiced CT surgery in an a academic environment for more that 30 years. I marveled and continue to marvel at the adversarial relationships between town & gown. I practiced in two communities. The solution is multifactorial, as the causes of adversarial relationships are many. I am personally interested in exploring methods by which both town and gown can achieve common ground.
- A must to explore.
- I would actively like to collaborate with the academic center. Distance is certainly a big obstacle, although I believe it would be extremely useful for thoracic surgery residents to rotate in a private practice where cost efficiency is an issue and where considerable innovation takes place, i.e., beating heart revascularization, early discharge process, robotic assisted surgery.
- Academic faculty time needs to be formally separated into teaching/clinical care vs. research/ administrative time. Private practitioners could participate equally with academic faculty in terms of teaching/clinical care time. In terms of reimbursement (% clinical, % teaching, % research, % administrative) and promotion tracks. Department chairman should have less discretion here and policies should be standardized throughout the institution--both in terms of

reimbursement, recognition, and clinical faculty promotion. Possibly in terms of clinical research, though not as the lead investigator.

- I would collaborate with an academic medical center.
- I do think that more collaboration between academic centers and private practice physicians is important.
- Barriers of prejudice must be broken. More open interchange for each to get to know the other better. Develop a willingness to share. Much of this participation to be done without concerns for financial compensation. Exchange visits to staff meetings for discussion of deaths and complications, case presentations, nature of research.
- 1 am semi-retired no longer participate in teaching of med students but that was big in my life. I think students learned much from exposure to private practice. House staff/students did not improve my patient care as they actually required additional time on my part, but it was worth it. I was always somewhat unhappy that I was not compensated for my time spent teaching but this would never stop me from doing it. In later years of my practice, academia became somewhat of an enemy as they worked very hard to extend clinical practice in to my community and competed very strongly for patients. Not a happy situation.
- Academic physicians are required to publish research papers, then teach students and residents. In my experience the research publishers are prorated over the teaching types, of course, because publishing adds more prestige to a university than teaching. Physicians in private practice tend to be business oriented and entrepreneurial—that is the more successful ones. I think some private practice

physicians would be willing to teach based on the time/income method of clinical practice. At least theoretically there exists a happy medium. It's your task to find it.

- I enjoy teaching and I believe many private practitioners feet the same way. Much of my surgical education came from private attendings. I would relish involvement in teaching if this could happen without disturbing today's delicate financial balance in my private surgical practice.
- I think it would be a great asset to the teaching program in a medical university if there were a cooperative program between those within and those outside the institution. From my observations, ego, and insularity among the chief of surgery and his staff are the main reasons that there is not the cooperative spirit among the two groups. Until this pettiness is solved, it will be difficult to use the outsiders as teachers. This is a shame as there are many surgeons in private practice who are excellent teachers and would willingly give time to a teaching program.
- Collaboration is essential for the future of medicine with the number of highly specialized physicians. The number of specialized physicians may be decreasing in the future, rendering collaboration paramount.
- Collaboration between private practice physicians and academic medical centers is a must for the continuing practice of medicine by both. There is no rational alternative.
- Another benefit for private practice MDs is possible—liability coverage which may reduce malpractice insurance costs. This is already being provided in Spartanburg, SC. Thanks.

- The private practitioner should be involved in collaboration because their patient outcomes should be part of any analysis of new therapies. Too often patterns of practice are directed by certain physicians who vary from established modes of therapy. This badly shows the results of tx. Secondly, the goals and philosophies of the academic physician and private practice doctor are very different. Both voices should be part of medical progress.
- My experience with academic med centers is now lopsided competition where they have the benefit of my taxes to compete with myself. They no longer take indigent patients, unless particularly interesting. Their track record speaks for itself
- It seems academic centers in my area are more interested in capturing as much patient referral base as possible. Damage to private physicians not considered and in fact seen as positive gain for the center. Medicine should not be confrontational between physicians.
- The trial must have academic merit and not merely as a marketing ploy. I recently had a patient who required transport to MUSC to treat glaucoma. The specialist at MUSC did not have privileges and could not come to St Francis where she was hospitalized. Interestingly- the patient had to be transported to MUSC for her eye treatments. St Francis had to be financial guarantor to MUSC. This cost the hospital a lot of money. This situation could have been remedied by allowing broader privileges to the treating consultant by St Francis - but also requires that MUSC grant privileges to MUSC staff to assist at teaching hospitals. This

situation is also applicable to proctors who could assist in educational endeavors at the private hospital.

- I had several positive encounters with academic medical centers. I referred a complex trauma case which they readily took in transfer, and I went to a "hands on" sential node mapping course. Both of these are examples of the need for a good relationship between private practice and academic medical centers. In my opinion, the most important collaboration would be improved patient care by DISCUSSING cases with the appropriate specialist and SOMETIMES electively referring patient for care. It is "easy" to get trauma patients to a medical center, and it is easy to go to a course. It is NOT easy, and often quite difficult to call a specialist and discuss cases and/or electively refer cases. It is hard to get through the communication system, and calls are often not returned for days, if at all. In addition, if you do get to talk with the ACADEMIC surgeon or physician, often times the conversation is not pleasant as you get the feeling that they are "put out". I find it is different and "easy" when I call a PRIVATE surgeon or physician for case discussions and elective referrals, even when they are associated with the medical center. I suspect that there is probably a lack of understanding about what academic and private community surgeons/physicians do that accounts for the communication problems i.e. one does not understand what the other does. The key to fix or repair this relationship, which ultimately and definitely benefit patients is going to be education, site visits and ongoing communication. I feel we can help the Academic medical centers by helping with the training of their medical students, residents, PA, NPs etc. They are always welcome. The few that

come report a good and enriched learning experience. As you can see I feel strongly about the above. Please call me with any questions. Good luck with the survey.

- Problem with definition of academic center. I practiced in a community academic center and found collaboration a mutual benefit for patients, institution, physicians, and residents. An academic center 200 miles away presents a different picture and role in medical care. In S.C. there are two major educational institutions and their role is clouded when they assume competitive attitudes in patient medical care rather than supportive roles in improving medical care. My answers are based on the assumption of a competitive institution 200 miles away.
- Given the decline in funding for academic centers, I feel it is imperative that private practice and academic centers join to: 1) Quality health care for all patients including indigent; 2) Resident exposure in broader base of clinical problems and practice aspects of medicine; 3) Opportunity for private practice physicians to interact with academic physicians to ensure continued education in latest treatment trials/options.
- One has to define academic medical center. In Greenville SC this means a large community hospital with a number of teaching programs ranging for family practice to OB/GYN, orthopedics, pediatrics to a fellowship in vascular surgery. There is a very large house staff as well basic research labs. In my opinion there are only two reasons that justify the hospital hiring MDs. 1) Teaching the house staff 2) to provide a medical service which can not be provide thru private practice. When the hospital goes beyond that and hires or acquires medical

practices it very quickly begins to compete with the private physician. This results in an adversarial relationship between the hospital and the private physician. The hospital in effect shoots itself in the foot because it is taking patients away from from the doctors it is dependent on to refer patients for admission. This is a no-win situation. Collaboration between private practice physicians and academic medical centers is a must for the continuing practice of medicine by both. There is no rational alternative.